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ROYAL COMMISSION OF INQUIRY INTO CERTAIN  
DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND  
RELATED MATTERS.

Hearing held  
8th floor  
180 Dundas Street West  
Toronto, Ontario

The Honourable Mr. Justice S.G.M. Grange

Commissioner

P.S.A. Lamak, Q.C.

Counsel

E.A. Cronk

Associate Counsel

Thomas Millar

Administrator

Transcript of evidence  
for

February 27, 1984

VOLUME 110

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ROYAL COMMISSION OF INQUIRY INTO CERTAIN  
DEATHS AT THE HOSPITAL FOR SICK CHILDREN  
AND RELATED MATTERS.

Hearing held on the 8th Floor,  
180 Dundas Street West, Toronto,  
Ontario, on Monday, the 27th  
day of February, 1984.

THE HONOURABLE MR. JUSTICE S.G.M. GRANGE - Commissioner  
THOMAS MILLAR - Administrator  
MURRAY R. ELLIOT - Registrar

APPEARANCES:

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D. HUNT )	General and Solicitor General
L. CECCHETTO )	of Ontario (Crown Attorneys
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I.J. ROLAND )	for Sick Children
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D. YOUNG )	Toronto Police
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	Children
B. SYMES )	Counsel for the Registered
E. McINTYRE )	Nurses' Association of Ontario
	and 35 Registered Nurses at
	The Hospital for Sick Children
H. SOLOMON	Counsel for The Ontario
	Registered Nursing Assistants

(Cont'd)



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APPEARANCES (CONTINUED)

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E. FORSTER	Counsel for Phyllis Trayner - Nurse
J.A. OLAH	Counsel for Janet Brownless - R.N.A.
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S. LABOW	Counsel for Mr. & Mrs. Gosselin, Mr. & Mrs. Gionas, Mr. & Mrs. Inwood, Mr. & Mrs. Turner, Mr. & Mrs. Lutes, and Mr. & Mrs. Murphy (parents of deceased children)
W.W. TOBIAS	Counsel for Mr. & Mrs. Hines (parents of deceased child Jordan Hines)
J. SHINEHOFT	Counsel for Lorie Pacsai and Kevin Garnet (parents of deceased child Kevin Pacsai).

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EMT.jc

A

1

2

--- Upon commencing at 10:00 a.m.

3

MEREDITH FRISE, (Resumed)

4

THE COMMISSIONER: Yes, Miss Symes?

5

CROSS-EXAMINATION BY MS. SYMES:

6

Q. Miss Frise, my name is Beth

7

Symes and I represent the Registered Nurses Association  
of Ontario and a number of individual nurses including

8

Bertha Bell and Karen Power.

9

10

When you were hired as a Registered  
Nursing Assistant at The Hospital for Sick Children  
in March of 1980 I gather that was just prior to  
the move to Wards 4A/4B?

11

12

13

A. That is right.

14

Q. And I gather that this was your  
first job as a registered nursing assistant?

15

16

A. That's right.

17

Q. So you were brand new to this  
profession?

18

A. That's right.

19

Q. And you were brand new to The  
Hospital for Sick Children?

20

21

A. That is correct.

22

Q. And you were brand new to  
cardiology?

23

24

A. That's correct.

25







A.2

1

2

Q. And at the move you were then

3

assigned to 4B?

4

A. That's right.

5

Q. And did you ever work on 4A?

6

A. Once in a while you may work

on 4A as a relief person.

7

Q. You were I gather on Karen

8

Power's team?

9

A. That's right.

10

Q. You were never on Phyllis

11

Trayner's team?

12

A. No, I was not.

13

Q. And just so I understand, Karen

14

Power's team is not the team that is parallel to the  
Trayner team?

15

A. That's right.

16

Q. In fact Karen Power's team was

17

parallel to Marie Mandal's team?

18

A. That's correct.

19

Q. So in other words the team

20

that you worked on, the Power team, would have followed  
or been opposite to the Bell team?

21

A. That's right.

22

Q. In other words, when you were

23

coming off the Bell team might be coming on?

24

25







A.3

1

2

A. That's correct.

3

Q. Or vice versa.

4

A. That is right.

5

Q. And then as a member of Karen

6

Power's team you would have received report from  
Bertha Bell's team?

7

A. That's right.

8

Q. You would not have received

9

report from Phyllis Trayner?

10

A. That's right.

11

Q. Or any member of her team?

12

A. That's right.

13

Q. Now when you were on the ward

14

it was the head nurse's job to evaluate the nurses?

15

A. Yes.

16

Q. On the ward?

17

A. That's correct.

18

Q. And I gather if you had seen a  
nurse do anything wrong you would have reported it to  
your head nurse?

20

A. That's correct.

21

Q. And I gather that at no time

22

during what we call the epidemic period did you ever  
report Phyllis Trayner to your head nurse?

23

A. That's correct.

24

25





A.4

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25

Q. Now I want to turn to March 23, 1981, and I gather that you attended at Phyllis Trayner's house prior to the meeting with Liz Radojewski at her house; is that right?

A. Yes, I did.

Q. And you identified on Thursday that Marie Mandal, Jane Partridge, Mary Jean Halpenny, yourself and Phyllis Trayner were present at that meeting?

A. That is right, yes.

Q. And I believe that you told us that Phyllis Trayner was the person who invited you?

A. Yes.

Q. And I believe you told us that Phyllis Trayner called you in the morning?

A. Yes.

Q. And that she asked you to come to her house to have a drink and something to eat?

A. That's right.

Q. And I believe you told us last day that you arrived at about 2 p.m.?

A. Yes.

Q. Now, was one of the reasons for the meeting or locating the meeting at Liz Radojewski's house that she had a new house?







A.5

1

2

THE COMMISSIONER: Sorry, is this the  
afternoon meeting or the night meeting?

4

MS. SYMES: The night meeting, sir.

5

THE COMMISSIONER: Yes. That is why  
I thought we were talking about the afternoon meeting.

6

MS. SYMES: I am trying to tie it in.

7

THE COMMISSIONER: Yes. All right.

8

Thank you.

9

MS. SYMES: Q. Was one of the reasons  
that the meeting scheduled for that evening was held  
at Liz Radojewski's because she had a new house?

10

11

12

A. Yes. Yes.

13

Q. And I gather you didn't know  
where that house was?

14

15

A. That's right.

16

Q. And many nurses didn't know  
where this house was?

17

A. That's right.

18

Q. But that Phyllis Trayner did  
know where it was?

19

20

A. Yes, she did.

21

Q. And I also gather that at that  
time Phyllis Trayner lived right near the Keele  
subway stop?

22

23

A. She lived near a subway stop. I

24

25







A.6

1

2

don't know whether it was Keele.

3

Q. Anyway, her place which was -

4

was very easy to get to?

5

A. Yes, it was.

6

Q. And that that was the reason

7

that a number of you agreed to meet at Phyllis Trayner's house; that you knew where that was and then you could

8

go as a group to Liz Radojewski's?

9

A. Yes, that makes sense, yes.

10

Q. Now you said that Phyllis Trayner

11

had invited you. Is that correct?

12

A. That's correct.

13

Q. And I gather, though, you were

14

the person who invited Jane Partridge to attend?

15

A. I cannot recall whether I did

16

that. I could have. I don't recall at this point.

17

Q. Well, is it possible that you

18

called Jane Partridge and invited her to come to

19

Phyllis Trayner's?

20

A. It could be possible, but as I

21

said, I don't really recall whether I did or didn't.

22

Q. I have spoken to her, and she

23

informs me - I just want to check with you that this

24

is so - that in fact you called her in the late after-

25

noon of March 23rd to invite her to come to Phyllis

26

Trayner's?

27





A.7

1

2

3

A. As I stated, I don't recall whether I phoned her at all.

4

Q. You don't recall?

5

A. No.

6

Q. And do you recall what time she would have arrived at this meeting?

7

8

A. No, I can't recall at this point when she arrived at the meeting.

9

10

Q. Is it possible it was close to 6 p.m.? That is, very late?

11

12

A. I don't really recall when she arrived there.

13

14

15

16

Q. In fact, Miss Frise, you had said yesterday that in answer to Mr. Lamek's question the meeting was about four hours long. Is it possible in fact that the meeting was very much shorter and that most people didn't arrive until about 6 p.m.?

17

18

A. No. From what I recollect I arrived there around two and we left at six.

19

20

Q. Okay. You arrived at about two but the other people could they have not come until six?

21

22

23

24

25

A. They could very well have. I don't really recall whether they came later or whether they came earlier.







A.8

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Q. It has been called a meeting  
but really it was a social event, wasn't it?

A. Yes, you could call it a social  
event, yes.

Q. You had pizza and coffee before  
you went to the meeting?

A. That is right.

Q. You said you are not sure or  
you don't recall if you called Jane Partridge. Is it  
possible that you were the person that invited other  
people? Marie Mandal, for example?

A. I do recall phoning Marie Mandal  
but I don't recall Jane Partridge.

Q. So you were the person that  
invited Marie Mandal to come?

A. That's right.

Q. Were you the person that invited  
Mary Jean Halpenny?

A. I don't recall.

Q. Might be?

A. Could be, but at this point I  
don't recall.

Q. I gather that any discussion  
that occurred would have occurred while you were  
eating and having coffee?







A.9

1

2

A. That's right.

3

Q. I believe that you had told

4

Mr. Lamek that Liz Radojewski had told someone that  
there was going to be a coroner's inquest into

5

Pacsai's death?

6

A. That's right, yes.

7

Q. And I gather you had never been

8

part of a coroner's inquest?

9

A. That's correct.

10

Q. Or investigation?

11

A. Right.

12

Q. And that you were nervous?

13

A. That's right.

14

Q. And I gather from what you told

15

Mr. Lamek that you also discussed that there had  
been a number of deaths on the floor?

16

A. Yes, there were.

17

Q. That was not news to anyone?

18

A. No, it was not news.

19

Q. And that you also told Mr. Lamek

20

the third thing was, that there was a concern that

21

maybe nurses were missing something; that is, not

22

picking up something with respect to the care of the  
babies?

23

A. That's correct.

24

25





A.10

1

2

Q. And that wasn't new, was it?

3

A. No, it was not.

4

Q. That had been raised by the  
nurses extensively?

5

A. Yes, it had.

6

Q. Over the period?

7

A. Yes.

8

Q. And that the deaths were  
occurring on 4A and particularly on Phyllis Trayner's  
team?

10

11

A. That's correct.

12

Q. And that wasn't you either?

13

A. No, it was not.

14

Q. The nurses all knew that?

15

A. Yes.

16

Q. And I gather then after you had  
your pizza and coffee you went off to Liz Radojewski's.

17

A. Yes.

18

Q. And you arrived there about  
7 o'clock?

19

A. Yes.

20

Q. Now at Liz Radojewski's I gather  
that you had told Mr. Lamek one of the things in  
discussion was that the nurses were looking for the  
cause of deaths?

22

23

24

25







A.11

1

2

A. That's right.

3

Q. And that the nurses were upset?

4

A. That's correct.

5

Q. And I gather again, just as you

6

discussed at Phyllis Trayner's, that the nurses were

7

concerned that they weren't picking up things quickly  
enough?

8

A. That's right.

9

Q. And that maybe a baby was

10

getting into trouble and they didn't notice it?

11

A. That's right.

12

Q. Again that was a theme that

13

had been repeated?

14

A. Yes.

14

Q. Not you?

15

A. No.

16

Q. I gather it also came up that

17

maybe a nurse had made a medication error?

18

A. Yes, it did come up.

19

Q. And so that is why there was

20

discussion about malpractice insurance?

21

A. Yes.

22

Q. And you have got that kind of

23

insurance through your professional association?

24

A. Yes.

25





B  
DM/cr

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25

Q. Miss Frise, the topic of intentional harm to a baby, was that discussed at all at that meeting?

A. No, I can't recall anything like that being discussed.

Q. And that didn't even cross your mind at that meeting, did it?

A. No, it did not cross my mind at that meeting.

Q. Now, you have told Mr. Lamek, Mr. Hunt and Mr. Percival, that you had asked Mary Costello if the deaths had anything to do with digoxin?

A. Yes, I did.

Q. I gather you had worked the long days on Sunday?

A. Yes, I did.

Q. And that was the day when digoxin was locked up?

A. Yes.

Q. Team leaders could not carry the keys?

A. That's right.

Q. And supervisors were on the floor?







Frise, cr.ex.  
(Symes)

1

2

A. That's right.

3

4

Q. And I guess while you were  
working you must have wondered why?

5

A. That's correct.

6

7

Q. And I gather you got no  
explanation whatsoever?

8

A. That's right.

9

10

Q. Do you remember if anyone  
even offered any statement as to why this was  
happening?

11

12

13

14

A. There was a bunch of them that  
went down to the 4A parent room and they discussed  
it. What was discussed in there, it was not passed  
on to me. I was asked to stay on the floor while  
they went in and talked to the supervisors.

15

16

Q. Did you ever hear the  
phrase "It's for your own good"?

17

18

THE COMMISSIONER: We are talking  
about as a nurse now.

19

Q. Yes.

20

A. Not that I can recall.

21

22

Q. But I gather from working  
the long days on Sunday you had no idea as to why  
these extraordinary measures were being taken?

23

24

A. That's right.

25





1

2

3

3

4

Q. And was one of your concerns that there was something wrong with the drug digoxin itself?

5

A. Yes.

6

7

Q. And was that discussed amongst the other nurses?

8

A. Yes, it was.

9

10

Q. Maybe there was something wrong with the strength of the concentration of digoxin?

11

A. That is correct.

12

Q. And is that why you asked that question of Mary Costello that night?

13

A. Yes.

14

Q. And I gather she said she couldn't comment, is that right?

15

A. That's right.

16

17

18

19

Q. Now this meeting that was held at Liz Radojewski's that night, it is not an unusual thing for nurses on your ward to meet to discuss problems, was it?

20

A. No, it was not unusual at that point, no.

21

22

23

24

25

Q. In fact that was the practice, that if you had a problem you generally met to try and straighten it out?







1

2

A. That's correct.

3

4

5

6

7

8

9

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22

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25

Q. And we have, for example, the Ward meeting books from 4A and 4B, which are Exhibits 300 and 301, and they show a number of meetings over the epidemic period?

A. Yes.

Q. And in fact this meeting at Liz Radojewski's was not the first time that you had met outside the Hospital?

A. No, it was not.

Q. We know that for example on October 22nd they met at your house?

A. Yes, they did.

Q. And were you present when the nurses met at Bertha Bell's?

A. No, I was not.

Q. But you know that it had occurred on a prior occasion?

A. Yes.

Q. And in fact in the fall of 1980 certain nurses were saying, let's hold these nurses' meetings outside the Hospital?

A. Yes.

Q. And the reasons for that were very simple, it was quieter outside the Hospital?





1

5

2

A. Yes.

3

Q. You wouldn't get any

4

interruptions?

5

A. That's correct.

6

Q. And nurses would be more

7

relaxed?

8

A. That's correct.

9

Q. Now, at the meeting at your

10

apartment on October the 22nd, 1980, there is in  
the notes a need for support meetings, do you recall

11

that?

12

A. Yes.

13

Q. And in answer to Mr. Lamek

14

on page 4716, you said that the support meetings  
started soon after, you are not sure in how many  
days, or a week?

15

16

A. No, I am not sure as to how

17

soon after it happened.

18

Q. On October 22nd, 1980, that

19

was after the death of a particular baby, you

20

recall then that there was a discussion of a need

21

for support?

22

A. Yes.

23

Q. And was there discussion also

24

of the need for perhaps you could have a psychiatrist

25







6 1  
2 as was available to the Intensive Care Unit Nurses?

3 A. Yes.

4 Q. And the other possibility is  
5 perhaps the Mental Health Nurse Andrea Frewin could  
6 get involved?

7 A. Yes.

8 Q. Now, Ms. Frise, to the best  
9 of your recollection when is the first time that  
10 the nurses met with a psychiatrist?

11 A. We used to always meet with  
12 him on a Friday, okay. I don't know what the day  
13 of October 22nd was, but from my best recollection  
14 I think it was the following Friday that that  
15 particular group met with him.

16 Q. There has been other people  
17 that have said they didn't meet with the psychiatrist  
18 until after Susan Nelles was arrested. Is it  
19 possible that you are mistaken and that the support  
20 meeting with the psychiatrist didn't occur until  
21 March of 1981?

22 A. I'm not sure about that.

23 Q. Do you ever recall meeting  
24 with Andrea Frewin?

25 A. No, I don't recall meeting  
with her.





1  
2 THE COMMISSIONER: I am sorry, who  
3 is Andrea Frewin?

4 MISS SYMES: Andrea Frewin is the  
5 Staff Mental Health Nurse.

6 THE COMMISSIONER: You never met with  
7 her at all?

8 THE WITNESS: No.

9 MISS SYMES: Q. So is it possible  
10 in fact that the support meetings didn't occur  
11 until after Susan Nelles was arrested?

12 A. When you say support meetings,  
13 you mean support meetings with the psychiatrist?

14 Q. Yes.

15 A. Like I said I am not really  
16 sure as to whether we started them before or after  
17 with the psychiatrist.

18 Q. Now after Susan Nelles was  
19 arrested, did you attend at these meetings with  
20 the other nurses and the psychiatrist?

21 A. Yes, I did attend them.

22 Q. And I gather that the fact  
23 that these meetings were held was well known to  
24 everyone?

25 A. Yes, it was.

Q. At some time did you become







1

2

aware of the police attitude towards those meetings?

3

A. Yes, I did.

4

Q. How did you become aware of  
it?

5

6

A. I became aware of it through  
Bertha Bell.

7

8

Q. And what did you understand  
was their attitude?

9

10

A. Their attitude that they were  
frustrated.

11

THE COMMISSIONER: Who were frustrated?

12

MISS SYMES: Q. The police, what  
was the police's attitude?

13

A. Towards the meetings?

14

Q. With the psychiatrist.

15

16

A. Okay, sorry. They were not  
too pleased about these meetings.

17

Q. Do you know why?

18

19

A. From what I recollect is  
that they thought we were all gathering together  
to put our evidence all together so everyone would  
tell the same story, which was not occurring at all.

20

21

22

Q. Now you have told Mr. Lamek  
that on June 17th, 1981, Constable Murray came to  
your parents' home in Peterborough to see you?

23

24

25





1

9

2

A. That's correct.

3

Q. And I gather he asked you if  
you knew anyone who was possibly holding back  
evidence?

4

5

A. That's right.

6

7

Q. And I gather that you answered  
Bertha Bell and Karen Power?

8

A. That's correct.

9

10

Q. And on Thursday you told  
Mr. Lamek that you had no information that either  
Bertha Bell or Karen Power were holding back  
information from the police?

11

12

A. That's right.

13

14

Q. And that is at page 4707 of  
the transcript. I also believe you told him that  
the only basis for that statement on June 17th  
was that Bertha Bell and Karen Power had met as  
friends with Susan Nelles after she was released  
on bail?

16

17

18

A. Yes.

19

20

Q. I believe you said that Bertha  
Bell and Susan Nelles were friends?

21

A. Yes.

22

Q. Are friends?

23

A. Are friends, yes.

24

25





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Q. And that Karen Power and Susan Nelles were friendly as well?

A. Yes.

Q. In April of 1981 when this happened, did you think that it was wrong for nurses who had been on Wards 4A/4B to meet socially with Susan Nelles?

A. Did I think it was wrong? I can't say that I thought it was wrong, I can't say that I thought it was right.

Q. Were you uncomfortable with it?

A. Yes.

Q. Now you obviously were not present at that social gathering?

A. That's right.

Q. But I gather after the nurses learned that it had occurred that Bertha Bell and Karen Power were quizzed by the nurses as to what had gone on?

A. Yes.

Q. They were quizzed at length?

A. Yes.

Q. And you knew that?

A. Yes.







1  
2  
11 3 Q. And they had told you, didn't  
4 they, that Susan Nelles had talked about --

5 THE COMMISSIONER: I am sorry, who  
6 are they?

7 MISS SYMES: They, Bertha Bell and  
8 Karen Power.

9 THE COMMISSIONER: Yes, all right.

10 MISS SYMES: Q. Bertha Bell and  
11 Karen Power had told the nurses that Susan Nelles  
12 had talked about how horrible it was to be in jail?

13 A. Yes.

14 Q. And that Susan Nelles talked  
15 about quilting?

16 A. Yes.

17 Q. So after the nurses had  
18 uquizzed Bertha Bell and Karen Power you knew what  
19 the content of that social gathering was?

20 A. That's right.

21  
22  
23  
24  
25  
- - - - -





BmB.jc  
C

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Q. And everybody, that is, Bertha

3

Bell and Karen Power assured everyone that nothing

4

had been asked and nothing had been said about the

5

deaths of the children?

6

A. That's right.

7

Q. So, you knew that?

8

A. Yes.

9

Q. Were you a little upset that  
you hadn't been invited to that social gathering?

10

A. No, I was not upset.

11

Q. Well, why did you think it  
stood out?

12

13

A. Why did what stand out, the  
meeting?

14

15

Q. The fact that Bertha Bell and  
Karen Power would meet socially with Susan Nelles?

16

17

A. In the fact that I guess only  
individual people were invited to come to the place  
and visit with her.

18

19

Q. And did you wish to be included?

20

A. No, I did not.

21

Q. Now, on June 17th, 1982 when  
Constable Murray came to Peterborough and asked you  
if you knew anyone who was possibly holding back  
evidence, and you answered, did he ask you the basis  
of your opinion?

22

23

24

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C.2

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A. No, he did not.

3

Q. Did you volunteer that basis?

4

A. Not that I can recall, no.

5

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THE COMMISSIONER: I'm sorry, I find that hard to understand. You mean to say that somebody was holding back evidence and the policeman didn't ask you what evidence was being held back and what you meant by it?

9

10

THE WITNESS: As I stated, I can't recall.

11

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THE COMMISSIONER: Well, there is quite a difference between you can't recall and saying you didn't say that. But it seems to me a pretty strange way for a policeman to behave if you said that and he didn't follow it up. But it may have been, it may have been, I'm not saying that. If you remember that he didn't, that's one thing, but if you just don't remember whether he did or not that perhaps is another.

18

19

20

THE WITNESS: I can say I don't remember if I did answer, like, say that I had a basis, I presume that he would have wrote it down on the statement.

21

22

23

24

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THE COMMISSIONER: No, that isn't the question. The question Miss Symes put to you, did he ask you what the basis was for your saying that Bertha Bell --





C.3

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THE WITNESS: No.

3

THE COMMISSIONER: -- was withholding

4

something?

5

THE WITNESS: No.

6

THE COMMISSIONER: And the answer is

7

he didn't?

8

THE WITNESS: He didn't.

9

MS. SYMES: Q. He didn't ask you the

10

basis?

A. No, he did not.

11

Q. And the second question is, did

12

you tell him the basis, did you volunteer it?

13

A. No, I did not.

14

Q. When you were cross-examined by

15

Mr. Hunt at pages 4756 through 4758 yesterday, you  
were asked:

16

Is there anything in Miss Bell's

17

attitude that you can recall that

18

would have raised that type of

19

question, that type of question in

20

your mind?

21

And you answered that --

22

MR. HUNT: What type of question is

23

that, just so the question is clear?

24

MS. SYMES: That type, in a rather

25





C.4

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long question starting on page 4755, Mr. Hunt asked  
you:

3

4

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"Now you told my friend Mr. Lamek  
this morning in June of 1982, you told  
Constable Murray from the Metropolitan  
Toronto Police that you -- in response  
to a question from him as to whether  
or not you thought there was anyone  
possibly withholding information, you  
gave the names Bertha Bell and Karen  
Power.

12

"A. That is right.

13

14

15

16

17

18

19

"Q. And you have explained as well  
to my friend Mr. Lamek and to the  
Commissioner in some questions asked  
by him, what the basis for that was.  
It involved the fact that you had  
been informed of a meeting that had  
taken place that apparently met with  
the disapproval of the police.

20

21

22

"Now, I think we can all appreciate  
that sometimes people have feelings  
that are difficult to put a finger on.

23

"A. That is right.

24

25

"Q. I want to ask you, is there or







C.5

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"was there at that time anything else about Bertha Bell that led you to feel that possibly she was withholding some information from the police?

"A. Nothing that I can recall, no.

"Q. Is there anything as you cast back through your memory that Bertha Bell said to you at any time that would have given you some reason to wonder in your own mind whether she was telling everything that she knew?

"A. Not that I can recall, no."

And then the question:

"Q. Is there anything in her attitude that you can recall that would have raised that type of question in your mind?"

It's not absolutely clear as to what that was. But you had answered that question that Ms. Bell was not pleased that the police would come and talk to her all the time?

A. That's right.

MR. HUNT: I don't see that answer. My friend has read now a page and a half of the build-up to this and then stopped at the precise





C.6

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2

point that makes it clear to the witness what she  
said last week.

3

4

THE COMMISSIONER: Yes.

5

MS. SYMES: The question was:

6

"Q. What was that?

7

"A. In her attitude in that she  
would state that the police would  
come -- the police would come and  
talk to her all the time; were always  
bugging her. That didn't please her  
at all. She wasn't pleased with that."  
That is exactly it, I have summed up  
the answer.

13

14

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MR. HUNT: Well, there is no need for  
a summary, Mr. Commissioner. We have a transcript  
for the answer. My friend obviously places great  
importance on this. She has led the build-up to it  
and if she intends to pursue it, I suggest the  
witness be informed accurately as to what exactly it  
was she said.

20

MS. SYMES: Q. Do you recall giving  
the answer?

21

22

A. Could I read the transcript,  
please?

23

24

25

Q. Sure.





C.7

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2

MS. SYMES: Could she please be given  
the transcript at 4757, please.

4

THE COMMISSIONER: Miss Solomon to the  
rescue. We don't have an extra copy.

5

6

MS. SYMES: Q. Do you have that?

7

A. Yes.

8

Q. Do you recall giving those  
answers?

9

A. Yes.

10

Q. Could you just leave the

11

transcript, please, I would just like to read on.

12

MS. SOLOMON: Yes.

13

MS. SYMES: Q. "Q. Is it fair to say  
that then you perceived in her attitude  
a rather negative response to the  
police efforts to ask her questions?

15

16

"A. That is correct, yes.

17

"Q. Was she rather vocal in that  
particular response that she had?

18

19

"A. What do you mean 'vocal'?

20

"Q. By vocal I mean did you hear her  
say it more than once?

21

"A. I think maybe I heard her say it  
twice."

22

23

THE COMMISSIONER: What is the question

24

25







C.8

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that you are asking?

3

MS. SYMES: I haven't come to the question, I'm just reading the transcript.

4

5

THE COMMISSIONER: Oh, all right.

6

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MS. SYMES: Q. When you had given this information, this opinion to Constable Murray on June 17th, 1982, were you aware that Ms. Bell had been interviewed three times by the police at The Hospital for Sick Children after Susan Nelles had been arrested and before the preliminary?

11

12

A. Yes, I knew that, yes.

13

14

Q. And you were aware that Ms. Bell had made no complaints about those three interviews?

15

16

17

18

A. That they had come once within that period, if I'm correct, to the Hospital and wanted to question her but she stated that she couldn't go down because the floor was uncovered and they weren't too pleased that she wouldn't come down.

19

20

Q. The three interviews occurred on March 26th, 1981, April 24th, 1981 and May 20th, 1981?

21

22

A. Yes.

23

24

Q. Shortly after the arrest of Susan Nelles. Do you recall with respect to those

25





C.9

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2

three interviews if Ms. Bell had any complaints, those  
three particular ones?

3

4

A. No, I can't recall.

5

6

Q. In fact, the complaints from  
Bell occurred after the preliminary, didn't they;  
after the preliminary was over?

7

8

A. Yes, I believe so, yes.

9

10

Q. And one of those was as a result  
of again after the preliminary the police came to  
her home on very short notice?

11

12

A. That's right.

13

14

Q. And Ms. Bell was upset that the  
police had come to her home because she had small  
children then?

15

16

A. That's correct.

17

18

Q. And that she wasn't unique, was  
she, that there were other nurses who didn't like the  
police coming to their home?

19

20

A. Yes.

21

22

Q. And that she had complained that  
the police had come to her home?

23

24

A. Yes, she did.

25

Q. And that was on one of the  
occasions that you heard her voice a complaint?

A. Yes.





C.10

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Q. Now, the second one, did Ms. Bell tell you that the police had arrived on the ward and that there had been some mix-up about scheduling her interview?

A. I believe that is correct, yes.

Q. And that she felt, Ms. Bell felt that she was unable to leave the floor because it was busy and she thought she was needed?

A. That's right.

Q. And did she also tell you that the police didn't understand that and that they had somehow threatened to report her to the Director of Nursing?

A. I don't recall that part.







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EMT/cr

Q. But you understood there was some misunderstanding or a disagreement as to whether or not Miss Bell could leave the floor at that time?

A. Yes.

Q. And go and speak to the police?

A. That's right.

Q. And she was a bit upset about that?

A. That's right.

Q. And is it fair to say if you were in her shoes you would have been upset as well?

A. Yes.

Q. Because as a nurse is your first priority to your patients that you are assigned?

A. That's right.

Q. So, Miss Frise, is it fair in sum that you have absolutely no basis in fact then for your statement that either Bertha Bell or Karen Power withheld evidence from the police?

A. That's right. That is what I stated before.

MR. HUNT: Well, Mr. Commissioner, my friend stopped and I was waiting to see whether





1  
2 at some point she was going to go on refreshing  
3 this witness' memory as to her answer the other  
4 day. She stopped about a page before it ended  
5 where the witness gives her evidence that she  
6 detected in what she heard from Bertha Bell, and  
7 I am looking at 4758, that she had - she agreed  
8 that one could describe the attitude that she per-  
9 ceived in Bertha Bell as one that did not sound like  
a very co-operative one.

10 Without refreshing the witness'  
11 memory as to that, and I don't know why my friend  
12 chose not to do that, she then asks is there no  
13 basis at all, and it is my submission the witness  
14 has given in her evidence last week the basis for  
15 feeling that she didn't feel this woman had a very  
co-operative attitude.

16 MISS SYMES: Well ---

17 THE COMMISSIONER: Let's just carry  
18 on, Miss Symes.

19 MISS SYMES: Q. Miss Frise ---

20 THE COMMISSIONER: I am sorry to say  
21 that I would much rather hear from Miss Bell, as we  
22 have, than hear from Miss Frise on this subject.  
However, you go ahead.

23 MISS SYMES: Well, Mr. Commissioner,  
24  
25





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it is very important to my clients that ---

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4

5

6

THE COMMISSIONER: It may be very important to your clients, but I don't know how it really helps us on the cause of death or the police investigation, but perhaps it does.

7

8

MISS SYMES: Well, Mr. Commissioner, yesterday she gave - last day she gave opinions that I submit were ill-founded.

9

10

11

12

THE COMMISSIONER: Yes, all right.

MISS SYMES: And my clients are very upset about it and have a reputation in the community.

13

14

15

16

THE COMMISSIONER: Well, yes, but I am not dealing with the reputation of a community. You understand that. I am not dealing with that. I am dealing with the cause of death of some 36 children - babies.

17

18

19

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MISS SYMES: Yes.

THE COMMISSIONER: And also with the police investigation. But I don't want this police investigation to turn into some kind of vendetta between the police and the nurses. The problem is whether the police investigated the matter properly. Isn't that the issue that is going to be before me.







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MISS SYMES: Mr. Commissioner,  
the police and the Attorney-General have clearly  
put in issue before you as to whether or not the  
nurses co-operated.

6

7

THE COMMISSIONER: Yes. All right.  
I started this off by saying I would rather hear  
from Miss Bell ---

8

9

MISS SYMES: Yes.

10

11

12

THE COMMISSIONER: - than I would  
from Miss Frise as to what was going on in Miss  
Bell's mind, and we have heard that. However, I  
am obviously not impressing this, so carry on.

13

14

MISS SYMES: Q. Miss Frise, last  
day you were asked the question on page 4758 about  
Miss Bell:

15

16

"Certainly it didn't sound like a  
very co-operative one, I guess.

17

A. I guess you can say that."

18

19

THE COMMISSIONER: Sorry, what page  
was that?

20

MISS SYMES: 4758, sir.

21

THE COMMISSIONER: Oh, yes. All  
right.

22

23

MISS SYMES: Q. Miss Frise, do you  
have anything, any basis for the statement that Miss

24

25





1  
5 2 Bell was not co-operative in sharing information  
3 with the police?

4 A. No.

5 Q. On page 4760 you were asked  
6 as to whether or not you had agreed with the  
7 assessment of the cardiologists as to the cause  
8 of death of the children, and you had told the  
9 Commission that there was a child who had died and  
10 that you did not explain - you did not, pardon me -  
11 accept the explanation given by the cardiologist,  
12 and this was a child who had had surgery, whose  
13 AP window had closed.

14 Do you recall talking about this  
15 child?

16 A. Yes.

17 Q. First of all, what is an AP  
18 window?

19 A. It is a shunt.

20 Q. A shunt? So this is a child  
21 whose cause of death was put down to that the shunt  
22 occluded or closed?

23 A. Yes.

24 Q. And you said that this child  
25 died on 4B?

26 A. Yes.





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2

Q. And that this child was in

3

Room 439?

4

A. That is correct.

5

Q. And that this child died at

night?

6

A. Yes.

7

Q. Were you on for the death?

8

A. No, I was not.

9

Q. You were not?

10

A. No.

11

Q. I have tried to go through

each of the children that died on 4B and I couldn't  
determine which one you were on.

13

A. I can't remember what the

14

child's name was.

15

Q. Okay. I am also unable to

16

determine any child that died in Room 439.

17

A. The child died there.

18

Q. You weren't there, though,

at the time of death?

19

A. I came on in the morning.

20

Q. And you can't recall when that

21

happened? In the epidemic period, from July until

22

March can you recall when?

23

THE COMMISSIONER: If it were a child

24

25







1  
2 that died either in the ICU or in the operating  
3 room we wouldn't be investigating the child, that's  
4 all.

MISS SYMES: Yes, sir.

5 Q. Miss Frise, I gathered from  
6 what you said that the child died on 4B?

7 A. That's right.

8 Q. And if I were to read you  
9 the names of the children who died on 4B, might that  
10 be of assistance to you?

11 A. It may be, yes.

12 Q. Laura Woodcock, who died the  
13 30th of June.

14 A. No.

15 Q. Taylor who died the 27th of  
16 July. Onofre who died the 9th of December.

17 A. Keep going.

18 Q. Could you say yes or no so  
19 the reporter can put it down.

20 Belanger who died the 28th of  
21 December.

22 A. No.

23 Q. Bruce Floryn who died the  
24 7th of February.

25 A. No.





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Q. Jordan Hines who died the 8th  
of March.

A. No.

Q. Manojlovich who died the 12th  
of March.

A. No.

Q. Kevin Paçsai who died the  
12th of March.

A. No.

Q. Kristin Inwood who died the  
13th of March.

A. No.

Q. I cannot find any other child  
that died on 4B.

A. I am sorry ---

Q. You can't help me?

A. I can't help you. If I know  
who worked that night, if we looked into the  
assignment book maybe you could find it.

Q. It is hard to do that without  
a date.

A. I don't recall as to what  
period it is, I am sorry.

MISS SYMES: Thank you very much.

Those are my questions.





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2

THE COMMISSIONER: All right. Thank

3

you.

4

I think we covered the second row.

5

Mr. Knazan?

6

MR. KNAZAN: I have no questions.

7

THE COMMISSIONER: You will come

8

later.

9

Mr. Olah?

10

MR. OLAH: No questions, Mr.

Commissioner.

11

THE COMMISSIONER: Mr. Labow?

12

MR. LABOW: Thank you, Mr.

Commissioner.

13

CROSS-EXAMINATION BY MR. LABOW:

14

Q. Good morning, Miss Frise.

15

My name is Stephen Labow. We represent the parents  
16 of six of the children, including Kristin Inwood and  
17 Barbara Gionas.

18

Now, the win sheets indicate that

19

you were on Ward 4B the night that Barbara Gionas  
20 arrested. Do you have any recollection about that  
21 arrest?

21

A. No, I do not.

22

Q. You were also on on the 11th

23

and 12th of March taking care of Kristin Inwood?

24

25







1

2

A. That's right.

3

4

MR. LABOW: Could the witness see  
the progress notes for Kristin Inwood, please?

5

6

Q. Kristin Inwood was admitted  
on the 11th of March and you were on long days?

7

A. Right.

8

Q. And when you see the progress  
notes, the first progress note is yours.

9

It is on page 61, Mr. Commissioner.

10

THE COMMISSIONER: Page 61?

11

MR. LABOW: 61.

12

Q. Now do you know if you admitted  
Kristin Inwood to the ward?

13

A. Yes, I did.

14

15

Q. Do you have any idea what time  
that was?

16

17

A. It was in the afternoon, I  
can't give the exact time.

18

19

Q. What did her condition appear  
to be like to you?

20

A. It appeared to be that she  
was in cardiac failure.

21

22

Q. Was she in very bad shape  
upon her admission?

23

24

A. She was in bad enough shape

25





1

and bad enough failure that she couldn't feed as is  
stated in this.

3

Q. Now do you know - you are not  
qualified as I understand it to give digoxin?

4

A. That's right.

5

6

Q. If digoxin is ordered?

7

A. That's correct.

8

Q. Do you know which of the other

9

nurses was supposed to be giving medications for  
you that day?

10

A. I can't recall who was giving  
my medications that day, no.

11

12

Q. When Kristin Inwood was  
admitted were you given any special instructions  
regarding her that you can recall?

13

14

A. No.

15

16

Q. We have heard that although  
digoxin was ordered digoxin was ordered held because  
her electrocardiogram showed signs of digoxin  
toxicity upon her admission.

17

18

19

Did you ever hear that or hear of  
that?

20

21

A. No.

22

Q. Do you know if she was given  
any digoxin on the 11th of March?

23

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A. I remember that there was a crisis that this child received digoxin that was not to receive digoxin.

Q. That was the next day?

A. I can't recall as to that day as to whether she did receive digoxin.

Q. Now the next day, and turn to page 62, your note is also there. You once more took care of Kristin Inwood on the 12th long day shift?

A. Yes.

Q. Is that correct?

A. Yes.

Q. Did you hear when you came in that morning that she had been given a mistaken dose of digoxin earlier?

A. I believe I did, yes.

Q. Were you given any special instructions regarding that?

A. No I was not.

Q. Did you know that digoxin had been placed on hold early that morning?

A. I can't say that I knew that, no.

Q. As a registered nursing







1  
2 assistant in charge of this child would you normally  
3 know if that was the case?

4 A. Yes, because you do look at  
5 the Cardexes and the medications that the child  
6 is on.

7 Q. During the day that you were  
8 there, aside from the fact that she wouldn't drink  
9 from the bottle, how did she appear on the 12th of  
10 March?

11 A. At times she appeared  
12 distressed.

13 Q. Could you turn to the page  
14 before, page 61? There is a note by Ms. Lyons.

15 A. Yes.

16 Q. Just under your note. And  
17 at the very bottom of her note it says "Condition  
18 in no apparent distress". Was that not your impression  
19 of this child?

20 A. That's not my impression. .  
21 Just reading by the vital signs this child was in  
22 distress.

23 Q. The vital signs noted by Miss  
24 Lyons?

25 A. That is right.

Q. Why do you say that?





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2

A. Well, she had a respiratory rate

3

of 60 to 100.

4

Q. And what should her

5

respiratory rate be?

6

A. Her respiration should be -

7

it shouldn't be up as high as 100. It should be

8

down into the 50s.

9

Q. Do you have any idea why

10

with those signs a nurse would write in no apparent  
distress?

11

A. No, I have no idea why

12

she would write that.

13

THE COMMISSIONER: Whose signature  
is that, do you know?

14

THE WITNESS: Yvonne Lyons.

15

MR. LABOW: Lyons, Mr. Commissioner,

16

L-y-o-n-s.

17

Q. In your note on the 12th, on

18

page 62, does it say - can you tell me what it says

19

for respiration?

20

A. It says respirations 98 to 58.

21

Q. Now that would mean to you that

the child was in some kind of distress?

22

A. At a point in time through

23

the day, yes.

24

25





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Q. And did you note that anywhere?

3

4

A. I didn't note it that she was in distress, but by noting that her respirations were high you can go by that.

5

6

Q. Do you recall telling anyone that this child was in distress?

7

8

A. If her respirations were up that high I probably would have told someone through the day.

9

10

Q. Who would you normally have told?

11

12

A. I would have told the girl that was in charge, the team leader.

13

14

Q. But you don't recall specifically?

15

16

A. As to whether I ---

17

Q. As to whether you did or did not on that day?

18

A. I don't recall.

19

Q. Did you think that Kristin Inwood was at imminent risk of death?

20

21

A. No, I did not.

22

Q. Were you surprised when she died?

23

A. Yes, I was.

24

25







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2

3

Q. Was it ever - did you ever  
bring it up to anyone, ask them why she had died?

4

A. No, ~~not~~ that I can remember.

5

6

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- - - -

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Q. Miss Frise, I would just like  
to ask you about one other thing.

Mr. Registrar, this is Exhibit 301.

At page 9 of Exhibit 301.

A. Yes.

Q. The second page of the note  
from a meeting on October 23rd that was apparently  
in your apartment; is that correct?

A. Yes.

Q. Now, at the very top of page  
9 there is a note concerning doctors. Could you  
tell me what the note says, please.

I'm sorry, Miss Cronk is going to  
give you the original document, and it will be a lot  
easier to read.

A. Okay. Thank you.

We were feeling that, as nurses, we  
were feeling that doctors were not passing on the  
messages as to how sick these children were and how  
close we should observe them, and then it follows to  
say that the Fellows, we were feeling that some of  
the Fellows and the Residents were not, did not seem  
to have enough experience in the cardiology field to  
warns us beforehand as to how sick the children were.

Q. Did you bring this problem  
up to anyone?





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A. This problem here? This

3

problem was discussed at this meeting.

4

Q. So it was discussed with your  
team leader?

5

6

A. It was discussed with whoever  
was at this meeting.

7

8

Q. Well, Karen Power was at the  
meeting.

9

A. Yes, she was. Yes.

10

11

Q. Now, the last sentence of  
that top note, can you tell me what it says please.  
Just read it out.

12

13

A. "Dr. Freedom blaming the  
doctors on account of they don't order  
the right meds."

14

15

16

Q. So that the word there is  
"blaming"?

17

A. "Blaming", yes.

18

MR. LABOW: Thank you. I have no  
further questions.

19

20

THE COMMISSIONER: Thank you, Mr.  
Labow.

21

Mr. Shinehoft?

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MR. SHINEHOFT: I have no questions,  
Mr. Commissioner.

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THE COMMISSIONER: Am I missing  
someone? I don't see anyone else around.

MR. LABOW: Mr. Shanahan told me if  
he wasn't here he had no questions.

THE COMMISSIONER: I hope he has lots  
of questions in Provincial Court.

Miss Solomon?

MS. SOLOMON: Mr. Tobias is not here.  
He did mention to me he had questions.

THE COMMISSIONER: Oh, yes, Miss  
Forster?

MS. FORSTER: Mr. Commissioner, before  
Miss Solomon proceeds, I wonder if I might ask a  
few questions arising out of the evidence on Thursday  
afternoon?

THE COMMISSIONER: Arising out of the  
evidence Thursday afternoon, yes.

FURTHER CROSS-EXAMINATION BY MS. FORSTER:

Q. Mr. Frise, you told Mr.  
Percival on Thursday afternoon that shortly after  
Susan Nelles was arrested you had lunch with Mrs.  
Trayner at the Eaton Centre.

A. That's correct.

Q. And do you recall how soon  
after Miss Nelles' arrest that lunch took place?





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A. No, I can't recall as to how soon after.

Q. Well, we heard evidence that the Trayner team was off duty for a while. Was it after Mrs. Trayner came back to work?

A. I am not sure.

Q. I understand that Lynn Johnstone was also present at that lunch, is that correct?

A. That is right.

Q. And during the course of the lunch the three of you discussed Susan Nelles' arrest?

A. Yes.

Q. And did you also discuss the fact that the police suspected that the four babies had died from an overdose of digoxin?

A. Yes.

Q. And I suggest that during the course of the lunch you also discussed where someone might find digoxin if they wanted to murder babies with it; is that right?

A. Yes.

Q. Do you recall Mrs. Trayner mentioning that when she had been questioned by the police they asked her that question, where someone





E5

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2

might get digoxin?

3

A. I can't recall her stating

4

that.

5

Q. You do recall however the

6

three of your discussed how one might get digoxin

7

if they were going to deliberately cause harm to

8

babies?

A. Yes.

9

Q. And I take it that during

10

the course of the lunch the point came up as to whether

11

you could buy digoxin in the drugstore?

12

A. Yes.

13

Q. And in particular whether

14

you could buy it over the counter, or whether you needed  
a prescription?

15

A. That's right.

16

Q. And you didn't know the

17

answer to that, I take it?

18

A. That's correct.

19

Q. And neither did Phyllis

20

Trayner?

A. That's correct.

21

Q. You were curious to find out

22

how easy it was to buy digoxin?

23

A. Yes.

24

25







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Q. And so was Mrs. Trayner?

3

A. Yes.

4

Q. And is that the reason that the two of you went to a drugstore, just to see how easy it was to obtain digoxin?

5

A. Yes, that makes sense. Yes.

7

Q. And that was in the context of this investigation into the deaths at Sick Kids?

8

9

A. Yes.

10

Q. And at the time you went to the drugstore, I take it the deaths on 4A and 4B had stopped, had they? You went after the epidemic period?

11

12

13

A. Yes.

14

MS. FORSTER: Thank you. Those are all my questions.

15

16

MR. ROLAND: Sir, I have a couple of questions arising out of the last question or so asked of this witness by Mr. Labow about the note on page 9 of Exhibit 301.

17

18

19

THE COMMISSIONER: Yes.

20

MR. ROLAND: Which he asked the witness to read. If I might --

21

22

THE COMMISSIONER: Yes. All right.

23

FURTHER CROSS- EXAMINATION BY MR. ROLAND:

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Q. Miss Frise, I take it Dr.

25





E7

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Freedom was not at the meeting himself?

3

A. That is right.

4

Q. And someone had said --

5

therefore, I gather someone at the meeting said  
something about Dr. Freedom?

6

A. Yes.

7

Q. Do you remember who that was?

8

A. No, I cannot remember.

9

Q. I gather it wasn't you,

10

although you recorded this? It was somebody else  
speaking --

11

A. That's right.

12

Q. -- when you recorded this?

13

A. Yes.

14

Q. And you have no idea who

15

said that?

16

A. No, I can't recall who said

17

it, I'm sorry.

18

MR. ROLAND: Thank you.

19

THE COMMISSIONER: Yes, Miss Solomon?

20

MS. SOLOMON: I have no questions,

Mr. Commissioner.

21

THE COMMISSIONER: Miss Cronk?

22

MS. CRONK: I have just one question.

23

REDIRECT EXAMINATION BY MS. CRONK:

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Q. Just one question, Miss Frise,

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if I might. You recall, Miss Frise, that your attention was drawn this morning, by Miss Symes, to the meeting that took place on Monday, March 23rd at Elizabeth Radojewski's house? Do you recall that?

A. Yes.

Q. And your attention was drawn, again by Miss Symes, this morning to the question which, as I understand it, you posed to Miss Costello and you told Mr. Lamek about this. You asked her whether or not some of the deaths, or what as you described as the whole thing that had been happening, had to do with digoxin?

A. Yes.

Q. That is the question you asked her; do you recall that?

A. Yes.

Q. As I understood your evidence last Thursday, Mr. Lamek asked you why you had posed that question to Miss Costello, and you offered him a number of reasons, and I would just like to review those with you.

You told Mr. Lamek, as I recall it, that you thought you asked that question because you had been at work on Sunday - that would have been Sunday, March 22nd?







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A. Yes.

3

Q. -- when you knew that the

4

digoxin had been locked up.

5

A. Yes.

6

Q. And that was one of the

7

reasons that you asked the question?

8

A. Yes.

9

Q. You also told Mr. Lamek, as

10

I understood it, that another reason you asked the

11

question was because when you were at work on that

12

Sunday, you had observed that supervisors were there

13

watching the nurses draw up digoxin and other

14

medications that were to be given to the patients on

15

the ward.

A. Yes.

16

Q. That was another reason?

17

A. Yes.

18

Q. And you also told Mr. Lamek,

19

as I understood it, that another reason you posed the

20

question was because you learned that very day, that

21

Monday afternoon, that Pacsai, Kevin Pacsai, had a

22

high digoxin level.

A. Yes.

23

Q. Do you recall saying that?

24

A. Yes.

25





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Q. And you learned as well that

there might be an inquest with respect to the death  
of Kevin Pacsai.

A. That's right.

Q. Was that another reason why  
you posed the question?

A. Yes.

Q. Then Miss Symes asked you  
this morning, or she suggested to you, that there  
might have been a problem with the strength of the  
digoxin itself that was available on the ward; do  
you recall that?

A. Yes.

Q. You told her, as I understood  
it, that that as well was why you asked Miss  
Costello that question about digoxin; do you remember  
that?

A. Yes.

Q. Is it fair to say, Miss  
Frise, it was the combination of all of those  
factors and all of those things that you knew and had  
observed that caused you to raise that matter directly  
with Miss Costello that night?

A. Yes.

Q. And it was in that context that





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you asked her that question and that she gave the  
answer you have described to us previously?

A. Yes.

MS. CRONK: Sir, I have no further  
questions of this witness.

THE COMMISSIONER: No. Thank you.

MS. CRONK: Thank you, on behalf of  
the Commission, Miss Frise.

THE COMMISSIONER: Thank you, Miss  
Frise.

Now, we are in trouble.

MS. CRONK: I'm afraid we are, sir,  
because our undertaking and representation, if you  
will, to Mrs. Radojewski was that she would not be  
available until 2:15 this afternoon. I can enquire  
whether she can be available sooner, but I am afraid  
I can give you no assurance on that.

THE COMMISSIONER: No. Do you know  
anything further on this?

MS. SYMES: I'm sorry, I don't. I  
can enquire as well.

THE COMMISSIONER: Let's see. Do  
you happen to know where she lives, or is she working  
or would she be at the Hospital?

MS. SYMES: Sir, she lives in the







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west end of the city and the only problem is child care for her new baby.

THE COMMISSIONER: Well, she has probably made all the arrangements for 2:15 and there may be nothing we can do about it.

MS. CRONK: The only compromise solution I can suggest, sir, I do not know whether it will be possible, but I can attempt, through Miss Symes, to contact Mrs. Radojewski, Mr. Commissioner, and see if she could start earlier this afternoon than 2:15.

THE COMMISSIONER: The trouble will be getting the message around.

MR. LABOW: I just spoke to Mr. Tobias and he had expected that Miss Symes would be about an hour, and he is actually on his way.

THE COMMISSIONER: Where is he on his way from?

MR. LABOW: Here, from his office.

THE COMMISSIONER: The trouble is if we put him in -- well, I don't suppose there is that much -- because if we have to -- well...

MR. LABOW: If we could take our morning break a little earlier and then allow Mr. Tobias his opportunity to cross-examine.





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THE COMMISSIONER: As long as I can  
also add that this will never, never, never happen  
again. Poor Miss Frise, she is the one who has to  
suffer for this. So, however, we will take our break  
and we will come back when Mr. Tobias arrives. If  
he arrives before quarter past eleven, but if he  
doesn't, we will retire until 2:15.  
--- recess.





F  
BM/PS

1  
2 ---Upon commencing.

3 THE COMMISSIONER: Yes, Mr. Tobias.

4 MR. TOBIAS: Mr. Commissioner, I  
5 apologize for any inconvenience I may have caused  
6 to you or to other counsel and I recognize that this  
7 is a one time indulgence for which I thank you, sir.

8 CROSS-EXAMINATION BY MR. TOBIAS:

9 Q. Ms. Frise, I had an opportunity  
10 over the weekend to have a look at Exhibit 334 which  
11 is the 4B WINS Sheets. Am I correct that basically  
12 on March the 6th and 5th, 1981, that would have been  
13 the Thursday and Friday you were off?

14 A. Yes.

15 Q. All right. I take it that in  
16 fact you were off for three days. The record seems  
17 to indicate that Wednesday and Thursday were regular  
18 days off and Friday was a statutory holiday that  
19 you took off.

20 A. That's right.

21 Q. All right. So, you would have  
22 reported for work then I take it on the long night  
23 shift of Saturday, the 7th of March.

24 A. That's right.

25 Q. All right. And what time would  
you have reported for work?





Frise  
cr. ex. (Tobias)

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A. 7:00.

3

Q. All right. Now, my information

4

is that the Hines baby had been admitted to the

5

hospital early on the morning of Friday, March 6th,

6

although he was seen in emergency during the evening

7

of Thursday, March 5th. I take it that prior to coming

8

on duty on March 7th you had not seen the Hines baby.

9

A. That's right.

10

Q. And in fact when you had intended

11

to start your shift at 7 on the 7th you would have had

12

no previous contact with that baby and you didn't

even know that he was there; is that correct?

13

A. That's right.

14

Q. Okay, fine. Now, on the 7th

of March do you recall what your assignment was?

15

A. I had four babies in 431; I

16

can't recall the names of them.

17

Q. Okay, fine. If I can assist

18

you just for a moment.

19

I am looking, Mr. Commissioner, at

20

the 4B assignment book, page 117, it appears that

on March 7th --

21

THE COMMISSIONER: What exhibit is

22

that?

23

MR. TOBIAS: I am not sure that the

24

25







1  
2 assignment book was a separate exhibit. It was 32A,  
3 the entire book.

4 MS. CRONK: 13, sir.

5 MR. TOBIAS: And I am referring  
6 specifically to the 4B assignment book now, page 117.

7 MS. CRONK: That's tab 14, sir.

8 THE COMMISSIONER: Thank you.

9 MR. TOBIAS: Q. Ms. Frise, from this  
10 exhibit it appears Babies Ho, Baker, Singh,  
11 Silva were in room 431 on the 7th as well as Hines.  
12 There were five babies. Do you have a clear recol-  
13 lection that Hines was not one of the babies that  
14 you were caring for?

15 A. That's right.

16 Q. All right. Who was caring  
17 for him?

18 A. Sue Reaper.

19 Q. So you would have been I take  
20 it caring for the other four babies.

21 A. That's correct.

22 Q. Do you recall anything about  
23 the medication that those other four babies were  
24 on, can you assist me at all?

25 A. All I can recall is one baby  
being on medication.





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Q. All right. And what kind of

3

medication, was that baby on digoxin?

4

A. Yes, it was.

5

Q. All right. Now, are you telling

6

me that with respect to the other three you just  
don't know what medication they were on?

7

A. I just don't remember at this

8

point.

9

Q. Okay, fine. As you know, there

10

has been evidence led here to indicate that the Hines

11

baby expired at around 6 a.m. on the 8th. So, I take

12

it that you would only have been present during

13

approximately the last 11 hours of the child's life.

14

A. That's right.

15

Q. Now, he went into arrest,

16

according to your note which appears in his

17

medical chart, at 4:10 a.m.

18

A. Yes.

19

Q. Did you have an opportunity to

20

observe the baby at all between 7:00 when you came

21

on shift and 4:10 a.m.?

22

A. Yes, I did.

23

Q. All right. Can you tell me what

24

his condition was at that time?

25

A. He was fine. I just looked at





1

2

the child.

3

Q. All right. Now, generally did you  
note any discomfort or stress at all in his condition  
or anything that would concern you whatsoever?

4

5

A. No, I did not.

6

7

Q. So, your recollection is that  
he was stable.

8

A. Yes.

9

10

Q. Now, I take it from that, that  
you did not at any time during those 11 hours hear  
either of his monitors go off.

11

12

A. That's right.

13

Q. And you didn't observe him  
being apneic or cyanotic.

14

A. That's correct.

15

16

Q. All right, fine. Now, were you  
aware, do you have any personal information - I  
don't want to know what you might have been told -  
do you have any personal information as to any  
episodes that Miss Reaper might have brought to your  
attention with respect to the baby that evening?

17

18

19

20

21

A. Yes, there was one respect  
where she had stated to me that the child's  
apex was up to 180.

22

23

Q. All right. And was that basically

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the only observation which she made that she communicated to you?

3

4

A. Yes.

5

Q. There were no other problems?

6

A. No.

7

8

9

10

Q. All right, fine. Now, can you tell us, and I am referring, Mr. Commissioner, to Exhibit 103 which is the Hines medical record, particularly page 35 thereof, there is a note at 4:10, Miss Frise, in your own handwriting, it says:

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12

13

14

"I, Meredith, was feeding a baby in Room 431. Monitor on Jordan went off and then stopped. I went to get up and check him. At that moment the apnea monitor went off."

15

16

Now, my first question to you is, the first monitor to go off, was that his apnea or his cardiac monitor?

17

18

A. His cardiac monitor went off first.

19

20

Q. All right. And once it came on did it stay on?

21

A. No, it shut off.

22

Q. All right. How long was it on for, do you recall, before it shut off?

23

24

A. Maybe a minute to two minutes.

25





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What page is that on?

3

THE COMMISSIONER: Page 35.

4

MR. TOBIAS: Page 35.

5

A. Thank you.

6

Q. When the monitor went off the first time what did you do?

7

8

A. I proceeded to get up to go towards the child to see if there was a problem.

9

Q. Yes.

10

11

A. And I sat back down because it had shut off.

12

Q. Because it...?

13

A. Had shut off.

14

15

Q. All right. So, did it shut off basically in the length of time that it took you to get up and approach the child?

16

17

A. I stood up out of the chair and sat back down again.

18

19

20

Q. All right. Now, you just previously told me that it might have stayed on for a minute or two. I take it in light of what you have just told me it was somewhat less than that?

21

22

A. It could have been.

23

24

25

Q. All right. Well, my point is it wouldn't take you very long to get up and





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approach the child, would it?

3

A. No. It could take a minute.

4

Q. All right. In any event, you recall that before you got over to the child to attend to him it went off?

5

6

A. Yes.

7

Q. All right. Then what did you do?

8

A. The monitor went off, it stopped, I sat back down, the monitor went off again, I proceeded to go over to the child.

9

10

11

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14

Q. All right. Now, do you have any recollection of how long transpired between the time that it went off that it stopped sounding for the first time and that you sat back down and it went off again?

15

A. Not very long.

16

Q. All right. Are we talking just a matter of moments?

17

18

A. Yes.

19

Q. Okay. And the second time it went off, what monitor was it that went off, do you know, was it the apnea or the cardiac monitor?

20

21

A. The cardiac monitor went off and then the apnea monitor.

22

23

Q. All right. So, do I have it

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25





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correct then that the first time it was the cardiac  
monitor only?

3

4

A. Yes.

5

Q. You got up, approached the  
child and it stopped sounding?

6

A. Yes.

7

Q. You settled back down.

8

A. Yes.

9

Q. Moments later the cardiac  
monitor goes off again.

10

11

A. Yes.

12

Q. You get up and approach the  
child and thereafter the apnea monitor goes off as  
well?

13

14

A. Yes.

15

Q. All right. What was the condi-  
tion of the child when you approached him with both  
monitors going off?

16

17

A. When I approached the child the  
child to my looking wasn't breathing. I touched  
the child, there was no response, I shook the child,  
there was no response.

18

19

20

21

Q. Yes. And what happened then?

22

A. At that point I called Mary  
Jean Halpenny to come into the room.

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Q. Yes. Now, your note indicates that when Mary Jean Halpenny came into the room she started C.P.R. Did she start that immediately?

A. No, she did not. She left the room because we weren't positively sure that the child didn't have an apex. She left the room to get a stethoscope.

Q. Yes.

A. I didn't have mine around my neck and neither did she. So, she left the room and came back. When she left the room I put my baby back. She checked, I checked and then at that point we started C.P.R.

Q. All right. Now, how long was she gone from the room, do you recall?

A. Not very long, maybe not even a minute.

Q. Okay, fine. And when she was out of the room were you still attending to the Hines baby?

A. I had proceeded to put the baby that I was feeding back into bed.

Q. All right. And then did you come back to the Hines baby?





11

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A. Yes, I did.

3

Q. And were you there before she  
got back with the stethoscope?

4

5

A. Yes, I was.

6

Q. What was his condition at that  
time, was he breathing or not?

7

A. He was not breathing.

8

Q. All right, fine. So, I take it  
that this incident at 4:10 was a fairly long period  
in which he stopped breathing; do I have that  
correctly?

11

12

A. When you say long period, long  
period that we got to the child?

13

Q. No, the total amount of time that  
you would have noticed him not breathing, would that  
have been more or less than ten seconds.

16

A. More than ten seconds.

17

Q. Considerably more, can you  
estimate for me at all how long that would have been?

18

19

A. No, I can't estimate, no.

20

Q. Do you recall if he changed  
color?

21

A. Yes, he did change color.

22

Q. All right, fine. Was he cyanotic?

23

A. Yes, he was cyanotic.

24

25





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Q. Okay. And what happened after

3

Mary Jean Halpenny started C.P.R., do you recall?

4

A. She had pushed the alarm buzzer

5

and at that point Phyllis Trayner and Sue Nelles had  
come in with the crash cart.

6

Q. Yes.

7

A. As well as Sue Reaper then

8

followed and Mary Jean started to bag the child and

9

Sue Nelles got in and started to do the compressions

10

on the child.

11

Q. All right. So, at that point

12

you were still in the room, I take it?

13

A. Yes.

14

Q. So, we have you, Sue Reaper,

15

Phyllis Trayner, Susan Nelles; was Mary Jean

16

Halpenny still there?

17

A. Yes, she was bagging the child.

18

Q. All right. Who else was there

at that point?

19

A. I said Susan Reaper, did I?

20

Q. Yes, you did.

21

A. No one else was there at that

point.

22

Q. All right. Now, I take it

23

ultimately a Code 25 was called?

24

25







13

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2

A. Yes, it was.

3

Q. Do you recall what doctor

4

responded to that Code 25?

5

A. Dr. Jeff Kobayashi.

6

Q. All right. And was there another  
doctor who later also joined him?

7

A. Yes, there was a few more doctors  
who joined him.

9

Q. I take it that one of those was

10

Dr. Costigan, he has given evidence that he was  
there during the resuscitation effort.

11

A. Yes.

12

Q. All right. Do you recall how

13

many doctors in total were there during the  
resuscitation effort?

14

15

A. Four or five.

16

Q. Okay. And was Dr. Costigan one

17

of the doctors who was present during the whole  
resuscitation effort?

18

A. Yes, he was.

19

Q. And was Dr. Kobayashi another

20

doctor who was present throughout the entire resuscita-  
tion effort?

21

22

A. Yes, he was.

23

Q. All right. Do you recall

24

25





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cr. ex. (Tobias)

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the names of any of the other doctors who were there?

3

A. No, I do not.

4

Q. All right. Now, with respect  
to nursing personnel.

5

A. Yes.

6

7

Q. Who was there throughout? In  
other words, you have indicated five nurses that were  
there when the Code 25 was called. Did they all stay  
there throughout the entire resuscitation effort?

8

9

10

A. From my best recollection, every-  
one stayed but Mary Jean Halpenny, she went out  
and would pop in back and forth.

11

12

13

Q. I see, all right. So, you stayed  
throughout the entire effort?

14

A. Yes.

15

16

Q. Susan Nelles and Phyllis  
Trayner stayed throughout the entire effort?

17

A. That's correct.

18

19

Q. Sue Reaper stayed throughout the  
entire effort?

20

A. That's correct.

21

Q. And in addition you said there  
were three or four doctors.

22

A. Yes.

23

24

Q. Is that your best recollection

25





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right now of all of the people who were involved in  
the resuscitation effort?

A. Yes. I said four or five  
doctors, didn't I?

Q. Now, I take it -- I'm sorry,  
four or five doctors?

A. Yes.

Q. All right. Prior to the child  
going into arrest, did you have any occasion whatso-  
ever to read his chart?

A. No, not that I can recall, no.

Q. All right. And when you came on  
duty that night were you briefed on that child's  
condition, did anyone discuss his condition with you?

A. Yes, I believe it was discussed  
briefly at report.





EMT.jc  
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Q. All right. Do you recall what was said at report?

A. I can recall that it was stated that this child - they were worried about apnea spells.

Q. Yes. And that is why he was on the monitor?

A. The apnea monitor, yes.

Q. Was anything else discussed at report?

A. Something about bradycardia and tachycardia.

Q. Yes. Anything else?

A. Nothing else that I can recall, no.

Q. What was the impression that you were left with as to the seriousness of the child's condition at report?

Let me assist you. Was this a child that they expressed any serious concern about? Was he expected to deteriorate? Was he in any danger of life threatening events?

A. No. No.

Q. Okay. Fine.

Now you told Mr. Lamek the other day in giving evidence that you were surprised at the







G2

1

2

death of some of these babies. Certain babies expired  
and you didn't expect them to?

4

A. Yes.

5

6

Q. And he asked you whether any  
in particular stood out in your mind?

7

A. Yes.

8

Q. Your response was, "Well, right  
off the top of my head, Jordan Hines"?

9

A. Yes.

10

11

Q. So I take it he stands out the  
most in your memory in terms of surprise?

12

A. Yes.

13

Q. And unexpectedness?

14

A. Yes.

15

Q. Can you tell me why, what  
caused you to give that response?

16

17

18

19

20

21

A. It was a surprise because we  
were not told that this child was not going to - was  
going to die. There was no warning beforehand that  
this child died. There was no warning that this child  
was in distress beforehand that we could jump in  
before he passed away. It was just it happened very  
quickly. The alarms went off and that was it.

22

23

Q. Was there anything else that  
helped you form that opinion of surprise? In

24

25





G.3

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particular, how long normally would a resuscitation effort go on for?

3

4

A. A normal resuscitation shouldn't last any more than an hour.

5

6

Q. All right. How long did this one last?

7

8

A. This one lasted to my best recollection until about quarter to seven. We were finished at quarter to seven.

9

10

Q. All right. He went into arrest somewhere between 4:10 a.m. and 4:30?

11

12

A. That is right.

13

Q. So by my calculations that would put it at almost two hours?

14

15

A. Yes.

16

Q. A little bit over two hours in fact. Two hours and fifteen minutes?

17

18

Q. Is that a particularly lengthy resuscitation effort?

19

20

A. Yes, it was.

21

Q. Was there any significance to that? Any special reason why the resuscitation effort would go on for so long?

22

23

A. It would probably go on for so

24

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long as they were - they couldn't understand why  
this child passed away.

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Q. Are you indicating that because  
of the suddenness and because of the fact that this  
was not a child who was expected to go into arrest  
and who was expected to die, that he would have,  
because of that, been a particularly good candidate  
for resuscitation, and that is why they worked on him  
for so long?

10

A. Yes.

11

12

Q. Is that basically what you are  
saying?

13

A. Yes.

14

Q. All right. Fine.

15

16

17

Now I understand at the preliminary  
hearing of this matter you gave some evidence  
regarding an incident that occurred between Phyllis  
Trayner and Susan Nelles during the arrest?

18

A. Yes.

19

20

21

Q. All right. And as you are aware  
Miss Coulson who testified immediately prior to you  
also gave some evidence as to that incident?

22

A. Yes.

23

24

25

Q. And I believe (correct me if I  
am wrong) you were here last Wednesday when she was







G.5

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2

giving that evidence, were you not?

3

A. Yes.

4

Q. So that you heard the evidence

5

given?

6

A. Yes.

7

Q. And you were familiar with it?

8

A. Yes.

10

Q. Can you tell me what incident

11

it is that I just referred to? What incident did you  
give evidence about at the preliminary inquiry?

12

A. The pacemaker incident?

13

Q. Yes. What about the pacemaker?

14

What happened?

15

A. There was an argument between

16

Phyllis Trayner and Sue Nelles as to which pacemaker  
should be used on the child.

17

Q. Okay. Now you chose the word

18

"argument". We have heard it characterized as a debate,  
as a discussion, as an argument.

19

You tell us since you were there what

20

was it in your opinion?

21

A. It was a disagreement.

22

Q. Okay. Do you still stand by the

23

word "argument" that you used earlier? Were they  
arguing or not?

24

25





G.6

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A. They were disagreeing.

3

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Q. Okay. Give me the intensity of the disagreement? Was it a heated disagreement, casual disagreement? Describe it to me, please.

6

7

A. I guess you can call it a heated disagreement.

8

9

10

Q. Were they talking in ordinary tones or were they hollering at one another?

11

12

13

A. They were not hollering at each other.

14

15

A. I was classified as the runner. The surgeon was going to put in pacer wires.

16

17

18

19

Q. Yes.

A. I think I went to get the pacer wires and asked him what size gloves he wore and got the gloves and pacer wires set up on the counter for him.

20

21

Q. All right. Now obviously you noticed this disagreement?

22

23

24

25

A. Yes, I did.

Q. Did you find it disturbing in the context of the resuscitation effort or not?





G.7

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A. I would say it was disturbing,  
yes.

4

5

6

Q. Did it in any way interfere with  
those duties that you had to perform during the  
course of the resuscitation effort?

7

8

9

10

A. No, it did not.

Q. Do you have any information as  
to whether or not it interfered with any of the other  
members present, members of the resuscitation team?  
Did anyone say anything to you afterwards?

11

12

13

A. No, they did not.

Q. Fine. How long did this dis-  
agreement go on for?

14

15

16

A. Twenty minutes.

Q. Okay. And while this disagree-  
ment was going on what were the doctors doing?

17

18

A. They were working on the child.

Q. All right. And in particular,  
can you assist me as to what they were doing?

19

20

A. They were prepping the child  
to put in pacer wires.

21

22

Q. Yes. What was the argument  
about, do you recall?

23

24

25

A. Yes. It was about which kind  
of pacemaker they were going to use.







G.8

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Q. All right. Now were you there when the doctor called for a pacemaker?

A. Yes, I was.

Q. Did he indicate what kind of pacemaker he wanted?

A. No, he did not.

Q. And as far as you know - I take it you have been in on resuscitation efforts before? This was not the first time?

A. That's correct.

Q. How many have you participated in?

A. I don't know the number.

Q. Well, are we talking more than 10?

A. You could say 10. More than 10.

Q. Okay. And have you had any previous experience with pacemakers?

A. Yes, I had.

Q. I take it you have been there before during a resuscitation effort when pacemakers were used in aid of the resuscitation effort?

A. It was talked about, yes, but never ever brought in and used.

Q. I'm sorry? I didn't hear.

A. It was talked about but it was never ever brought in and used.







G.9

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Q. All right. Do you know - do you have any information as to whether it makes a difference to the resuscitation effort itself as to what kind of pacemaker you use?

A. Yes, it would.

Q. Okay. Can you tell me what that difference is?

A. There are two different pacemakers. One pacemaker is a demand pacemaker. The other one is a sequential pacemaker.

Q. Yes.

A. And it involves in the demand pacemaker the child's heart can beat on its own, and the demand pacer will kick in when the child's heart goes below a certain rate.

Q. Yes.

A. The sequential pacemaker will help the child's heart just beat, period.

Q. I see. So that in terms of the utility of it, it would be the second kind of pacemaker that you refer to --

A. Yes.

Q. -- that would be the more desirable?

A. Yes.





G.10

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Q. But do you agree with me that both kinds would get an impulse going?

A. That's correct.

Q. And isn't that really what you are trying to do when a child is in cardiac arrest?

A. Yes.

Q. Get an impulse going?

A. Yes.

Q. And doesn't it matter how fast you get that done?

A. Does it matter how fast?

Q. How fast you get the impulse going? I take it it is good; it is something that you want to accomplish if you can get it done very quickly?

A. Yes.

Q. And in that regard it really wouldn't matter, would it, because either pacemaker would get an impulse going?

A. Yes.

Q. And the real issue is that you should get the pacemaker as quickly as possible?

A. That is correct.

Q. All right. Fine.

Now, Miss Coulson gave evidence that at one point during this discussion Dr. Costigan had





G.11

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2

to ask Susan and Phyllis to be quiet, and I believe  
her words were "Let's calm down, ladies".

4

Do you recall him saying that?

5

A. I have to say, no, I can't  
recall him saying that.

6

7

Q. All right. You weren't there,  
though, at all times during the resuscitation effort  
because you were a runner as you have indicated?

9

A. Yes. Yes.

10

11

Q. So that I take it there were  
brief time periods when you would have been out of  
the room?

12

13

A. Yes, but I wasn't out of the  
room right at the initial argument or disagreement  
over the pacemaker.

14

15

16

Q. And were you in the room the  
entire time that argument or disagreement was ongoing?

17

A. Yes.

18

19

Q. Fine. You have no recollection  
of the doctor having to ask them to --

20

A. No, I can't remember.

21

Q. -- to quiet down?

22

A. No.

23

Q. Did you think that it was a good  
idea for them to quiet down?

24

25







G.12

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A. Yes, it would have been a good idea.

Q. Do you agree with me that this discussion really didn't do much to aid and advance the resuscitation effort?

A. Yes, that's right.

Q. It would have been better frankly if it hadn't happened? Do you agree with that?

A. Yes.

MR. TOBIAS: All right. Fine.

Those are all my questions.

THE COMMISSIONER: Yes. All right.

Thank you.

Miss Solomon?

MS. SOLOMON: No questions.

THE COMMISSIONER: Miss Cronk?

MS. CRONK: No questions, sir.

THE COMMISSIONER: We once again thank you and I suggest that you make a very speedy retreat from here before somebody else turns up.

--- Witness withdraws

THE COMMISSIONER: Now what about the room?

MS. CRONK: Sir, we have a room, Hearing Room No. 3.





G.13

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THE COMMISSIONER: For when, this

3

afternoon?

4

MS. CRONK: This afternoon.

5

THE COMMISSIONER: This afternoon at

6

2 p.m.?

7

MS. CRONK: Yes.

8

THE COMMISSIONER: All right. We are  
going to ask counsel to meet in Hearing Room No. 3.

9

MS. CRONK: Hearing Room No. 3 at 2 p.m.

10

THE COMMISSIONER: At 2 p.m. this

11

afternoon. It has to do with the evidence, and it is  
a meeting in camera so we will meet at 2 o'clock.

12

13

MS. CRONK: It being the intention

14

then, sir, that we will resume at 2:15 or as shortly  
thereafter as we can.

15

THE COMMISSIONER: That is right.

16

--- Luncheon recess.

17

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AA  
DM/PS

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---Upon resuming at 3:05 p.m.

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THE COMMISSIONER: Yes, Ms. Cronk.

4

MS. CRONK: Good afternoon, sir. Our  
next witness, sir, is Ms. Elizabeth Radojewski.

5

ELIZABETH RADOJEWSKI, sworn.

6

DIRECT EXAMINATION BY MS. CRONK:

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11

Q. Ms. Radojewski, it is sometimes  
difficult to hear in this room and I would ask you if  
you could when you have your discussions over the next  
day or so if you could just lean forward to the mike  
a little bit.

12

13

14

As I understand it, Ms. Radojewski,  
you enrolled in a Registered Nursing Diploma  
Course at the Hospital for Sick Children in  
September of 1967, is that correct?

15

16

17

18

A. Yes, I did.

19

20

21

Q. You graduated from that course  
successfully in 1970 with a Registered Nursing  
Certificate?

22

23

24

25

A. Yes.

Q. You were then that very year, in  
September, hired by the Hospital for Sick Children as  
a Staff Nurse?

A. Yes, I was.

Q. What ward did you first work on





1  
2 at the Hospital for Sick Children?

3 A. I worked on the Burn Unit,  
4 Ward 8E.

5 Q. And you were transferred, as I  
6 understand it, at a subsequent point to the  
7 Cardiac Unit, that was in 1972, I have been informed?

8 A. Yes.

9 Q. And was that on Ward 5A at the  
10 time?

11 A. Yes, it was 5A.

12 Q. And initially were you employed  
13 on that ward as the staff nurse?

14 A. Yes.

15 Q. Did you then subsequently become  
16 promoted to the position of team leader on Ward 5A?

17 A. Yes, I did.

18 Q. And subsequently as a teaching  
19 team leader again on the same ward?

20 A. Yes.

21 Q. In October, 1975 I have been told  
22 that you left the Hospital for Sick Children on an  
23 educational leave of absence for approximately six  
24 months.

25 A. Yes.

Q. And where did you work during that







1

2

six month period?

3

A. I worked at Great Ormond Street  
Hospital in London, England.

4

5

Q. And that was, as I suggested, for a  
six month period?

6

7

A. It was either six to eight months,  
I am not quite sure.

8

9

Q. Did you then return to Toronto  
into employment at the Hospital for Sick Children?

10

A. Yes, I did.

11

Q. In what capacity?

12

A. Staff nurse on Ward 7G which  
was the Neonatal Intensive Care Unit.

13

14

Q. And subsequently did you again  
return to the cardiac unit?

15

A. Yes, I transferred back to 5A.

16

Q. Do you recall now when that was?

17

Was this shortly after your return to the Hospital  
for Sick Children?

18

19

A. I spent about, between six to  
eight months in the neonatal ICU, so it was after  
that time I transferred, I believe it was December  
or November.

20

21

22

Q. And that would have been in

23

1976?

24

25





1

2

A. Yes.

3

4

Q. And when you returned to Ward 5A did you return to the position you formerly held, and that is a teaching team leader on that ward?

5

6

A. Not immediately.

7

Q. Subsequently you again achieved that position on the ward?

8

A. Yes.

9

10

Q. What position did you hold on Ward 5A at the beginning of March, 1980, Ms. Radojewski?

11

12

A. Teaching team leader.

13

14

Q. And when the ward relocated to Wards 4A and 4B you were promoted as we have heard to head nurse on Ward 4A, is that correct?

15

A. Yes.

16

17

Q. And Mary Costello had been the previous head nurse on Ward 5A in its entirety?

18

A. Yes.

19

20

Q. She then assumed the position of head nurse on Ward 4B, effectively the same time as you assumed those duties for Ward 4A, is that correct?

21

A. Yes.

22

23

Q. During the period April, 1980, through to the end of March, 1981, did you continue to

24

25





1

2

hold the position of head nurse for Ward 4A?

3

A. Yes, I did.

4

Q. You do not, as I understand it,  
hold that position today, is that correct?

5

A. That's correct.

6

7

Q. You left the employ of the  
Hospital for Sick Children at some point after  
April of 1981?

8

9

A. Yes, I did.

10

Q. When was that?

11

A. I left the employment in  
February of 1982 on maternity leave.

12

13

Q. Since then have you returned to  
work outside the home with any medical care institu-  
tion?

14

15

A. No, I have not.

16

17

Q. Counsel has been kind enough to  
provide to me, Ms. Radojewski, a copy of your curriculum  
vitae. Could you look at it for a moment please,  
and tell me if it accurately sets out your educational  
and employment background?

18

19

20

A. Yes, it does.

21

THE COMMISSIONER: Exhibit 363.

22

MS. CRONK: 363, sir?

23

THE COMMISSIONER: That's right.

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MS. CRONK: Thank you.

3

---EXHIBIT NO. 363: Curriculum vitae re. Elizabeth  
Radojewski.

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Q. Ms. Radojewski, I would ask you  
to look for a moment if you would at the time period  
described on your curriculum vitae for the period  
when you were on six month educational leave of  
absence, it is expressed as having been the period  
of October, 1975 to April, 1981, I assume that that  
is a typographical error?

11

A. Yes.

12

Q. And it should read through  
April, 1976.

13

14

A. That's right.

15

16

17

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19

20

Q. Thank you. Ms. Radojewski, on  
the basis then of the various positions that you have  
held at the Hospital for Sick Children, and as well  
the positions that you held in London, England, do I  
have it correctly that by July of 1980 you had had  
almost 8 years of experience as a nurse in  
pediatric cardiology?

21

A. Yes.

22

23

Q. When you were employed as the  
head nurse for Ward 4A, can you tell us please what  
your normal hours of duty were?

24

25





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A. The normal hours were 7:15 in the morning until 3:45 p.m.

3

4

Q. Did you on occasion work the long night shift or the evening shift?

5

6

A. No, I did not.

6

7

Q. Did you have occasion from time to time to work the weekends as the head nurse on Ward 4A?

8

9

A. Not in the capacity of the head nurse, I did work weekends occasionally.

10

11

Q. And in what capacity would you do that?

12

13

A. As a nursing supervisor.

13

14

Q. How often would you do that?

14

15

A. It was about one in eight weeks.

15

16

Q. Once every eight weeks you would work both days of the weekend, Saturday and Sunday?

17

A. Usually Saturday and Sunday.

18

19

Q. As a nursing supervisor did you have responsibility on those weekends for Ward 4A and Ward 4B?

20

21

A. Yes, I did.

22

23

Q. Would you have then been the only nursing supervisor in the hospital on those two days?

24

25





1

2

A. No, I wasn't.

3

4

Q. How many would have been on duty  
from time to time on those weekends?

5

6

A. There was an area coordinator  
who was in charge of the whole hospital, and again  
another head nurse from the medical area.

7

8

Q. So two to three at any given  
time?

9

10

A. Usually the three of us were on  
the weekends.

11

12

Q. When you were assigned to work  
weekends were you invariably assigned to supervise  
Wards 4A and 4B?

13

14

A. Yes.

15

16

17

Q. When you were on Ward 5A, that is,  
before the relocation of the cardiology unit to  
Wards 4A and B, Ms. Radojewski, did you have occasion  
then to work long night shift duty?

18

19

20

A. Yes, I did occasionally.

21

22

Q. And did you as well have occasion  
then to work the evening shift duty from time to  
time?

23

24

25

A. No, I believe I just worked  
long night duty.

Q. When you were working on 5A did







1

2

you have occasion to work with Susan Nelles?

3

A. On 5B?

4

Q. Yes.

5

A. Yes, I did.

6

Q. Did you have occasion as well to  
work with Phyllis Trayner on Ward 5A?

7

A. Yes, I did.

8

9

Q. Did you have occasion to work with  
the other members of the Phyllis Trayner nursing  
team on 5A?

10

11

A. Yes.

12

Q. With the exception, I take it, of  
Janet Brownless.

13

14

A. Yes, and Mrs. Scott.

15

Q. You did not work with Mrs. Scott  
on Ward 5A?

16

A. Oh, I'm sorry, I did.

17

18

Q. Do I have it correctly that you  
did have occasion to work with all of the members of  
Phyllis Trayner's nursing team on Ward 5A with the  
exception of Janet Brownless?

19

20

A. Yes.

21

22

Q. We have heard from Ms. Costello  
that her duties as head nurse on Ward 4B included  
management of patient care, ensuring the quality of

23

24

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1  
2 patient care, ensuring as she described it, the  
3 patient's nursing needs were analyzed and were met  
4 on a timely basis; the management of staff needs  
5 including budget responsibilities. In broader, general  
6 terms, Ms. Radojewski, is that an accurate description  
7 of what your own duties and responsibilities were as  
8 head nurse on Ward 4A?

8 A. Yes, it is.

9 Q. Did your duties require you as  
10 head nurse to monitor and assign specific nursing  
11 duties by various nurses who worked on 4A?

12 A. Yes, it did.

13 Q. Can you help us please, in  
14 respect of the assigning of patient assignments, when  
15 would you perform that function on a daily basis?

16 A. I would do the patient  
17 assignments for the shift from 3 to 7 p.m. when I  
18 came on in the day; and I would do the assignment  
19 for the long night shift that day; and I would do  
20 the assignment for the next day from 7 until 3.

21 Q. And in assigning various nurses  
22 to the care of specific children, I take it then that  
23 on any given day when you were working the eight hour  
24 day shift, you would plot the assignment effectively  
25 for the next 24 hours.





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A. Yes.

3

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Q. Did you record those in the  
assignment books that we have heard were maintained  
on Ward 4A?

5

6

A. Yes, I did.

6

7

8

Q. And when the long night staff,  
particularly the team leader on long nights came in  
to work would it be within her authority to check the  
patient assignments you had made during the day?

9

10

A. If she felt that she had to, yes.

11

12

Q. And if she were to do so would  
that be recorded in a special or specific way?

13

14

A. She would usually erase the  
assignment that I had done and put in her own, and  
I was told verbally about it the next morning.

15

16

17

18

19

Q. When you say she would erase the  
assignment that you had done, I take it she would  
actually erase the entry that you had made in the  
assignment book and replace it with the name of the  
individual she was assigning?

20

21

22

23

24

25

A. Yes.

Q. And with respect to the assign-  
ments which were to apply on weekends, did your  
responsibilities extend on Fridays to assigning  
specific nurses to specific patients for weekend





1

2

duty?

3

A. I did the assignment for the

4

day shift on Saturday from 7 until 3.

5

Q. Did you do any other assignments  
for weekend duty?

6

A. No.

7

Q. Whose responsibility was it to  
complete those assignments?

8

9

A. The team leader in charge of the  
ward for the weekend.

10

11

Q. And would that be the team leader  
who assumed duty on the long night shift on Friday  
evening?

12

13

A. It was usually the team leader  
who was in charge on the day shift, 7 to 3 on  
Saturday.

14

15

16

Q. On Saturday?

17

A. Yes.

18

Q. And in addition to the other

19

general responsibilities that you have outlined for  
us, what specific staff were you responsible for  
on an ongoing basis as head nurse on 4A?

20

21

A. Specific staff, the teaching

22

team leader had some responsibility to me; the

23

team leaders; registered nurses and registered nursing

24

25







1

2

assistants.

3

4

5

Q. And with all of those groups of people was your responsibility confined to those who worked on 4A as distinct from 4B?

6

A. Yes.

7

8

9

10

Q. When you say you were responsible for the team leaders on 4A and the registered nurses, I take it then that you would have been responsible for all of the nursing teams that were classified as 4A teams?

11

A. Yes.

12

13

Q. And that would include Phyllis Trayner's nursing team?

14

A. Yes, it would.

15

16

17

Q. Did your staff development responsibilities, if I can describe them as such, extend to the undertaking from time to time of written staff evaluations?

18

A. Yes, it did.

19

20

21

Q. And did your responsibilities in that regard extend both to registered nursing assistants and to registered nurses who worked on 4A?

22

A. Yes.

23

24

25

Q. Can you take us very briefly





1  
2 through your responsibilities on an average 8 hour  
3 day shift when you were working, Ms. Radojewski? What  
4 would the very first thing be that you would do when  
5 you arrived at work?

6 A. Usually I arrive shortly after  
7 7, and I would just have a small chat with the people  
8 on night to see how the night had gone and if there  
9 were any problems with the staffing. At 7:15 I  
10 would go in to take report with the rest of the  
11 nurses from the ward that were on duty that day.  
12 That would take anywhere from 20 to 30 minutes.  
13 When we came out the team leader and I would go  
14 over our plan for the day, such as children going  
15 for different tests. We would, if there were  
16 relief staff to be oriented to the ward for that day,  
17 she would look after that. If there was time we did  
18 a nursing round before we took the residents on rounds.  
19 Meaning --

20 Q. I'm sorry, go ahead.

21 A. If the team leader was new on  
22 duty that day, had been off for a couple of days, then  
23 I would take her around and refresh her memory and tell  
24 her what had gone on in the past two or three days.

25 Q. If I could stop you there for  
a moment. You have told me that at approximately 7:15





1

2

in the morning you would take report?

3

A. Yes.

4

Q. And where normally did you take

5

that, where was the physical location on the ward  
where you took report?

6

A. Yes, 4A took their report in the  
conference room.

7

8

Q. And who was expected to be at

9

report, other than yourself?

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A. The nurses who were on duty  
for that day and night nurse who gave us report.

Q. And you told us that that  
would take anywhere from 20 to 30 minutes, so I take  
it by twenty-five to eight or a quarter to eight  
in the morning normally you would be finished taking  
report?

A. Yes.

Q. All right. And then time  
permitting you would do a series of nursing rounds?

A. Yes.

Q. All right. And who would  
accompany you on those rounds?

A. Usually it was just the  
team leader and I.

Q. All right. And what was the  
purpose of that?

A. That was really to bring her  
up to date on things that had gone on on her days  
off.

Q. All right. And you have  
mentioned something as well about rounds that you  
did with Residents.

A. Yes.







BB2

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Q. When were they done?

3

A. From eight until eight-thirty.

4

Q. And who would accompany you

5

on those rounds other than the Residents?

6

A. The team leader would come

7

as well.

8

Q. And how long would they

normally take?

9

A. Anywhere from 20 to 30

10

minutes.

11

Q. We have heard as well that

12

at nine o'clock in the morning on Wards 4A/4B there

13

were certain specific medications that were required

14

to be given to patients including the drug digoxin.

15

Does that accord with your recollection of the practice  
on the ward?

16

A. Yes.

17

Q. All right. Did you as head

18

nurse have any involvement in overseeing or checking

19

the digoxin medications that were to be given at

20

nine o'clock in the morning on the day shift?

21

A. No.

22

Q. All right. Did you have any

23

responsibility to ensure as head nurse that those

24

medications had been given, given in the correct

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amount and to the correct patient?

A. No, that responsibility was given to the team leader and the night nurse in charge usually checked to see that they had been given when she did her paperwork at night.

Q. All right. Now, after you had completed the rounds with the Residents and with your day shift team leader what normally would your duties then encompass, very briefly?

A. The team leader and I shared transcribing of doctors' orders, if there were any orders before they went off to their other meeting at 8:30, we would look at placement - we had already assigned the placement of admissions the day before usually, but occasionally we had extras in. We would look at placement of transfers. There would be time hopefully to go through the charts, and that didn't happen every day. I am not sure what else you're asking for the rest of the day.

Q. All right. You have told me that you did do rounds at the beginning of the day with the team leader and also rounds with the Residents when they arrived on the ward. Would there be any occasion after nine o'clock in the morning through to the end of your shift at about 3:45 in





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the afternoon when you would have occasion on a regular basis to again do a nursing round?

A. Yes, I did a nursing round with my team leader before I left for the day.

Q. All right. And at what time during the day approximately according to routine would you do that round?

A. That occurred usually anywhere from 2:30 until four.

Q. All right. Do I have it correctly then that on a regular basis you, as the head nurse on that ward, would see each child on the ward perhaps briefly but nonetheless see the child at least three times every day?

A. Yes.

Q. And were there occasions when you did nursing rounds more than twice on an 8-hour day shift?

A. Yes, there were when the cardiologists were in charge, depending on the cardiologist in charge of the ward. There were his rounds at certain times of the week.

Q. All right. So that you could see each patient on the ward as many as four times during the day?







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A. Yes.

Q. And that's assuming that no emergency or critical condition had arisen in which case you would see I take it the patient again at that time?

A. Yes.

Q. All right. At the end of your shift, again an 8-hour day shift, was there a formal report in which you participated to brief the oncoming nurses?

A. No.

Q. All right. How then was the status of the patients on the ward communicated to the evening nursing shift when you left?

A. The team leader would give report to any nurses that were coming on from what you call the evening shift from three to seven.

A. And you have told us that your hours normally on an 8-hour day shift terminated at about 3:45 in the afternoon?

A. Not always, but yes.

Q. Well, when as a matter of normal routine would you leave the ward when you were working an 8-hour day shift?

A. Usually it was after four.





BB6

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Q. Much after four?

3

A. No, no, close to four.

4

Q. All right. Can you tell us

5

as well, Mrs. Radojewski, for the benefit of under-

6

standing what happens on the wards during the days

7

whether or not there were relatively fixed intervals

8

for the taking of breaks by nurses during the day

shift?

9

A. Usually their break time

10

occurred anywhere from 9:30 until quarter to eleven

11

in the morning, and that's taking into account the

12

time that they spend waiting for the elevator and

13

coming back from the cafeteria.

14

Q. All right. Was that at that

point a coffee break or a lunch break?

15

A. That was a coffee break.

16

Q. Were they as well entitled

17

to a lunch break during the course of the day shift?

18

A. Yes, they were. That usually

19

started about 11:30 or quarter to twelve and that

20

could happen until 1:30.

21

Q. Were there any other breaks

during the course of a normal day shift to which the

22

nurses under your charge were entitled?

23

A. They would start an afternoon

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coffee break, the nurses that were on a 12-hour day. They could start that at 2:30 and that may go on until about just before four.

Q. And whose responsibility was it to assign for any given nurse on the day shift the timing of her particular breaks?

A. It was usually the team leader's job.

Q. If the nurse who was entitled to take either a coffee break or a lunch break on the day shift had been assigned to constant nursing care duties, whose responsibility was it to assign a relief nurse to take over her responsibilities while she was on her break?

A. It was the team leader's duty to assign but we often checked it over together.

Q. All right. Would there be any record kept of those nurses who relieved for constant care nurses during the day?

A. There may have been some notations made on the assignment book.

Q. Was that required or would that be simply a matter of fortune, if you will, if you were trying to go back and determine it?

A. A matter of fortune.







1  
BB8 2 Q. It wasn't required that a  
3 record be kept?

4 A. We had a large piece of  
5 paper that also was the assignment for the day posted  
6 on the ward and that is where it was written down  
7 definitely, but it didn't always make it into the  
8 assignment book.

9 Q. Were those sheets of the  
10 daily assignments kept on a regular basis?

11 A. No, they were discarded.

12 Q. All right. Were they dis-  
13 carded on a daily basis or were they accumulated over  
14 a period of time and then destroyed?

15 A. I believe they were discarded  
16 on a daily basis by the ward clerks.

17 Q. You have told us, Mrs.  
18 Radojewski, that although you did not work the long  
19 night shift on Ward 4A, you did have that experience  
20 on Ward 5A and of course some of your own nurses on  
21 Ward 4A would on occasion be working the long night  
22 shift. Do I have that correctly?

23 A. Yes.

24 Q. To the best of your knowledge,  
25 were there fixed intervals at night when nurses were  
to take their entitled break periods?







B B9

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A. I don't recall that they were actually fixed times. In my recollection, the nurses tended to take their breaks at times that were less busy, that is, at peak times they didn't take their breaks and those were usually times when vital signs were being taken, infants needed to be fed and if there were any treatments to be done they took them at less busy times. It was not as structured as it was on days..

Q. Well, do I have it that nurses who were working the long night shift would be entitled, as were their counterparts during the day, to at least two coffee breaks and a lunch or dinner break?

A. Yes, they often combined them, but yes.

Q. All right. Well, assuming that they took them separately, we have heard that there were set medications that were to be given at nine o'clock on the ward during the long night shift.

A. Yes.

Q. Would it be your expectation that any of the nurses on Ward 4A would take a coffee break before the giving of those nine o'clock medications?





1  
BB1 2 A. Not usually, no.  
3 Q. And that would be I take it  
4 a relatively busy time on the ward?  
5 A. Extremely busy.  
6 Q. So, would it be fair of us  
7 then to assume that the first coffee break period  
8 would commence after the giving of the nine o'clock  
9 medications?  
10 A. Yes.  
11 Q. All right. Similarly, having  
12 regard to what you know of the activity on the ward  
13 during a long night shift, is there a time period  
14 within which you would have expected the nurses to  
15 take their lunch or dinner breaks?  
16 A. Yes, there is a time period.  
17 Q. When would that be, between  
18 what hours?  
19 A. More than likely between  
20 one-thirty and three and then again perhaps a short  
21 break before the morning, but the first few hours of  
22 the morning shift, meaning the end of their shift,  
23 are extremely busy as well.  
24 Q. So that in the normal course  
25 of events I take it you would not expect nurses to  
take their lunch or dinner break on the long night





BB11

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shift before one in the morning?

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A. I don't think so.

4

5

Q. All right. And then finally they would be entitled to a second coffee break some time before the shift ended at 7:15 in the morning?

6

7

A. Yes.

8

Q. All right. Now, you have told us that the giving of medications --

9

10

MR. HUNT: I'm sorry, I'm confused about that, Mr. Commissioner. I thought the witness had said that it was between 1:30 and three that it was extremely busy.

11

12

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THE COMMISSIONER: No, I thought that was --

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MS. CRONK: The lunch break.

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THE COMMISSIONER: Well, perhaps I'm wrong but I thought that's when you expected the lunch break to be, isn't that correct?

18

THE WITNESS: Yes.

19

20

THE COMMISSIONER: It's not a particularly busy time, or is it?

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THE WITNESS: The nurses do a vital sign routine usually every four hours. That's the usual routine unless there is something more going on. So, they are busy at twelve and at four. So, very







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often between twelve and four there is a long lunch  
break on nights.

MR.HUNT: The thing I think that  
confused me was I thought the witness said the first  
few hours of the early morning are busy.

THE WITNESS: I'm sorry. I referred  
to that as the end of the long night shift.

MR. HUNT: What hours?

THE WITNESS: That's what it means to  
me, because I work days.

MR. HUNT: What hours were you re-  
ferring to?

THE WITNESS: The first few hours that  
were busy?

MR. HUNT: Yes.

THE WITNESS: Usually between four  
and seven.

MR. HUNT: Oh, all right, I see,  
thank you.

MS. CRONK: Q. So that I understand  
it as well and I should clear this up for others  
including myself, you have told us that there are  
a number of busy times during the course of a 12-hour  
long night shift.

A. Yes.





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Q. And do I have it correctly that one of those times is at 9:00 or thereabouts for the giving of medications at nine o'clock?

A. Yes.

Q. All right. Is that the first period that you would expect, other than the period when they were taking report and coming on duty, that would be particularly busy for those long night shift nurses?

A. Yes, it is a busy time.

Q. When after the giving of the nine o'clock medications would you expect it next to be a particularly busy period on the ward?

A. If there are a lot of children on vital signs every four hours, the next busy time is twelve.

Q. All right. And that is because vital signs would be taken at that time?

A. Yes, and usually children wake up.

Q. As a standard matter was it a usual and frequent practice that vital signs were ordered every four hours?

A. It was the routine pretty well.

Q. All right. So then do I take





BB14

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it correctly that they would be taken at eight o'clock  
in the evening?

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A. Yes.

5

Q. And then at twelve o'clock?

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A. Yes.

7

Q. And then again at four o'clock?

8

A. Yes.

9

Q. Between the hours shortly

10

after midnight when those vital signs had been  
completed at four o'clock in the morning, would there  
be any particular period in those four hours which  
you would expect to busy for the nurses on that ward?

11

12

13

A. Unless there was something  
else that needed to be done, like treatments or  
infants being fed.

14

15

Q. There would not be?

16

A. I don't think so.

17

Q. All right. So that during that

18

period you have told us you think starting at about  
1:30 in the morning nurses would take their lunch  
or dinner break?

19

20

A. Yes.

21

Q. And then at four o'clock in

22

the morning if vital signs were being taken again  
that would be another busy period?

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A. Yes.

Q. All right. And would there be another particularly busy period between four in the morning and 7:15 in the morning when the shift ended?

A. Usually after six, from six until the shift ended was a busy time.

Q. And why was that?

A. There may have been children to prepare for the operating room, children to prepare for cardiac cath. There was charting to be done as well and it was a busy time.







EMT.jc  
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Q. During those periods during the 12-hour night shift when it was busy for the nurses on 4A, I assume that each would have her particular duties and responsibilities to fulfil.

A. Yes.

Q. Would it be fair of us to assume as well that during those peak periods if I can describe them that way, none of the nurses would be on a break but rather they would be attending to what their particular duties were at the time?

A. I would hope not.

Q. Most of them would be on the ward if not all of them?

A. Yes.

Q. What does the term "constant nursing care" mean to you, Mrs. Radojewski, as Head Nurse of Ward 4A?

A. Constant nursing care means that there is one nurse to look after the needs of the patient, of one patient, and it usually implies that the child is of a critical nature.

Q. In a critical condition?

A. Yes.

Q. When you worked as the Head Nurse





CC.2

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of 4A assigning nurses to constant nursing care did you differentiate between registered nurses and registered nursing assistants?

5

A. Yes, I did.

6

Q. Who would normally be assigned to constant nursing care duties?

7

A. Usually a registered nurse was.

8

9

10

11

12

Q. When a nurse who had been assigned constant nursing care duties was to take a break, whether it be an official or unofficial one, was there a rule or practice in place on the ward insofar as you were aware that dictated who was to relieve her?

13

14

15

A. I don't know that there was a rule but it was understood that a nurse of equal calibre would then relieve for the constant care nurse.

16

17

18

Q. Were there situations then when registered nursing assistants would relieve for registered nurses?

19

A. There may have been on occasion.

20

21

Q. As Head Nurse on 4A would that in your view be a desirable practice?

22

A. No, it was not a desirable practice.

23

24

25

Q. Did you encourage that?





CC.3

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A. No, I did not.

3

Q. Was it then your preference that  
a registered nurse relieve a registered nurse?

4

5

A. Yes.

6

Q. Was there any procedure in

7

place insofar as you are aware on Ward 4A at night  
which suggested that registered nursing assistants

8

could relieve registered nurses who had been assigned  
to constant nursing care duties?

9

10

A. Can you repeat the beginning  
of that again, please?

11

12

Q. I am sorry, it is an awkward  
question.

13

14

Was the situation any different at  
night insofar as you are aware?

15

16

A. No. I don't believe that it  
was different.

17

18

Q. Was it still expected that a

registered nurse then would relieve a registered nurse  
if she had been assigned to constant nursing care  
duties?

19

20

A. Yes.

21

22

Q. You have told us as well that

once in approximately every eight weeks you worked

23

weekends as a nursing supervisor, and when you did so

24

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CC.4

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you would have responsibility for Ward 4A. Do I  
have that correctly?

3

4

A. Yes.

5

6

Q. When you did so what were your  
normal hours of duty?

7

8

A. They were similar, from 7:15 a.m.  
to 3:45 p.m.

9

10

Q. Did you ever have occasion to  
work as nursing supervisor on Ward 4A or 4B on the  
night shift?

11

12

A. No.

13

14

Q. When you were working the then  
eight-hour day as a nursing supervisor what were your  
duties and responsibilities in general terms with  
respect to Ward 4A/4B?

15

16

17

18

19

20

A. In general terms it was to  
check on staffing to make sure that they had adequate  
staffing, to check on the condition of certain  
patients who might be listed on the tour end report,  
and I made a nursing round at least once if not twice  
a day.

21

22

Q. When would be the first time  
that you would physically be on Ward 4A/4B when you  
were acting as a nursing supervisor?

23

24

25

A. As I came on duty I would pass





CC.5

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through 4A/B before I went to nursing office.

3

Q. Where was the nursing office

4

located?

5

A. It was on the 4th floor but

6

in the Gerrard Street wing.

7

Q. That would place it then in

8

terms of time at approximately 7 or 7:15 in the morning?

9

A. Yes.

10

Q. When would you next be on

11

Ward 4A/4B?

12

A. That was usually sometime

13

after nine. I would start my rounds on 4A/4B.

14

Q. When you worked as nursing

15

supervisor on the weekends were you normally

16

assigned responsibility only for Ward 4A/4B or did you have in addition other wards to attend to?

17

A. I had 10 or 11 other wards to

18

attend to.

19

Q. You say you would start your

20

rounds on 4A/4B. Were those the first wards then on

21

which you did perform rounds when acting as nursing supervisor?

22

A. Yes.

23

Q. And as a matter of general

24

25





CC.6

1

2

practice would that tend to be approximately 9 o'clock  
in the morning?

3

4

A. Or shortly after nine, yes.

5

Q. How long would those rounds

normally take?

6

A. Usually about 15 minutes.

7

Q. All right. Who would accompany

8

you on those rounds?

9

A. The nurses in charge of the wards,

10

the respective wards, would accompany me on rounds.

11

Q. As nursing supervisor would you

12

have had made available to you the tour end reports

13

for the patients on those two wards that day?

A. Yes.

14

Q. Apart from the rounds that you

15

did at approximately nine in the morning did you as

16

well do a second nursing round on 4A/B when you were

17

working as nursing supervisor?

18

A. I usually tried to. I would

19

make sure that I would see any children who were on

20

the tour end report.

Q. And if you did do a second round

21

would there be a standard time when you would normally

22

try to achieve that?

23

A. I used to start a round shortly

24

after two.

25







CC. 7

1

2

Q. In the afternoon?

3

A. I would start my afternoon

4

rounds, yes.

5

Q. In addition to the conducting of formal rounds on one or two occasions during that eight-hour shift if there was an emergency of any kind that arose on the ward would I be correct in assuming that you would be on the ward then as well?

9

A. Yes.

10

Q. You would be summoned and you

11

would come to see what the emergency was?

12

A. Yes. I carried a beeper.

13

Q. All right.

14

But we know, Mrs. Radojewski, that following the relocation of the Cardiology Unit to Ward 4A and 4B at the beginning of April 1980 Ward 4A had 12 infant beds and Ward 4B had 6.

17

As between the two wards in your experience is it fair to suggest that 4A had physical capacity for more infant patients and therefore from time to time in fact housed more infant patients as between those two wards?

18

19

20

21

A. Yes.

22

Q. Miss Costello has told us,

23

however, and this, sir, is found at Volume 93, page

24

25







CC.8

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957, that there was not in her judgment nor her experience a distinction drawn between the two wards, in the sense of which ward would receive more gravely ill patients.

In your experience, Ms. Radojewski, was there a distinction drawn between the two wards in that sense?

A. I was left with the impression in that period of time that we had received some iller infants, yes.

Q. Was that on a regular basis, Ms. Radojewski, or was it at a particular time period when you felt that had happened?

A. The time period from when the ward opened, 4A opened, until after March, 1981.

Q. Are you saying then that throughout the entire period from April 1980 until after March of 1981 you had the impression, rightly or wrongly, that Ward 4A was receiving sicker patients than was Ward 4B?

A. Yes, I was left with that impression.

Q. What was the basis for your impression?

A. We seemed to be using more





CC.9

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equipment that we would need for children, infants, who were quite ill; we needed more monitors and more intravenous monitoring equipment. We seemed to be constantly shuffling beds to accommodate small infants in our room next to the nursing station. And I don't have any statistics with me but it is an impression I am left with, yes.

Q. We know, Mrs. Radojewski, that the capacity of Ward 4A to take more infants was confirmed by the fact that there were six more infant beds on that ward than 4B?

A. Yes.

Q. But I take it we can agree that merely because a patient was an infant did not necessarily place that patient in the gravely ill category?

A. That is right.

Q. So that there may at any given time be more infants on 4A but they may not be the most gravely ill patients on the two wards at that time; is that fair?

A. That is fair.

Q. And as between the two wards again are you suggesting that Ward 4A had a higher requirement for IV monitoring equipment than did Ward 4B?





CC.10

1

2

A. It seemd that way at the time.

3

Q. Well, was there more on 4A than

4

4B?

5

A. We shared equipment.

6

Q. So that whatever IV monitoring

7

equipment there was available on the Cardiology Unit  
was available mutually for both wards?

8

A. Yes.

9

Q. To the best of your knowledge

10

during that period of time, some 12 months, were there

11

any doctors or physicians who discussed with you

12

the assigning of the more gravely ill patients to

13

your ward as opposed to Ward 4B?

14

A. I find that - I get confused

15

when we had two cardiologists cover the wards. Can  
you repeat that again for me, please?

16

Q. During that some 12-month

17

period of time did you have any discussions with

18

any of the staff cardiologists or other physicians

19

on the wards in which it was suggested that the more

20

gravely ill patients should be placed on Ward 4A

21

as opposed to Ward 4B?

22

A. No.

23

Q. Did you have any discussions

24

with Mary Costello about that matter?

25







CC.11

1

2

A. No, not that I can recall.

3

Q. I'm sorry?

4

A. Not that I recall.

5

Q. Do I take it then it was your

6

impression, given your exposure to the wards, that  
Ward 4A had a great many sick patients?

7

A. I felt that, yes.

8

Q. As Head Nurse on Ward 4A would

9

you on all occasions when you were at work be

10

familiar with the patients on Ward 4B who were regarded

11

as being in critical condition?

12

A. Not necessarily all the time.

13

Q. Do I take it then that although

14

it would be preferable there might be occasions when

15

there could be gravely ill patients on Ward 4B

16

without your being aware of that fact?

17

A. There could be times, yes.

18

Q. As a normal matter, however,

19

when Mrs. Costello was on the eight-hour day shift

20

and you were on as well, did you communicate with

21

one another to brief each other, if you will, as to

22

which patients were gravely ill on both wards?

23

A. We may have at times, yes.

24

Q. Well, is it your recollection

25

that was a matter of practice between you as the two





CC.12

1

2

head nurses on that unit?

3

A. I don't recall for sure.

4

5

Q. I take it there would be times, however, when you would be aware as to the identity of the sicker patients on Ward 4B?

6

7

A. Yes.

8

9

10

11

12

Q. We have also heard from Ms. Costello that the younger more gravely ill patients on Ward 4B at least were generally assigned to Room 431 on that ward even if that meant having to move a patient out from that room to make room for a new admission or a new patient being transferred in.

13

Was that true as well for Room 418 on Ward 4A?

14

15

A. Yes.

16

17

18

Q. All right. Were there particular nurses that you as the Head Nurse on Ward 4A sought to assign to Room 418 and the patients that were in 418 from time to time?

19

20

21

A. Usually on the nursing team the nurse that followed the team leader in the so-called hierarchy was a very capable nurse and she was usually assigned the sicker children.

22

23

24

25

Q. All right. Do I take from that that in your view it was a desirable end to have very





CC.13

1

2

capable experienced nurses assigned to duties in that room?

3

4

A. Definitely desirable.

5

6

7

8

9

Q. And when you as the Head Nurse on 4A were assigning particular patients to particular nurses, both for the day shift, the long night shift and the evening shift, was it one of your objectives to see to it that the more experienced nurses were assigned to patients in that room?

10

A. Yes.

11

12

13

Q. To the best of your knowledge was that practice followed on Ward 4B by Ms. Costello as well?

14

A. I assume it was, yes.

15

16

17

18

19

20

21

22

23

24

25

Q. All right. We have heard, Mrs. Radojewski, as perhaps you are aware, evidence from a number of witnesses concerning medication errors that occurred or may have occurred on Wards 4A/4B during the nine-month period of time from July 1980 through to the end of March 1981. And it has been suggested by Ms. Costello, and this evidence, sir, is found at Volume 93, page 1033, that if a medication error occurred on either of those two wards the person who made the error or the person who detected the error, whichever it might be, would







CC.14

1

2

be required to complete and file an incident report  
in respect of that error.

3

4

Was that the practice on Ward 4A?

5

A. Yes.

6

7

Q. And if an error had occurred  
during the day shift when you were on duty is that  
a matter which of necessity would be brought to your  
attention as Head Nurse?

8

9

A. Yes.

10

11

12

Q. Would you be required to  
participate in the completion of an incident report  
or to at least review an incident report before it  
had been completed by others?

13

14

A. I usually viewed the incident  
report before it was completed.

15

16

17

18

19

Q. And if a medication error  
occurred on Ward 4A during the long night shift or  
during the evening shift is that a matter that would  
be brought to your attention when you were next on  
duty at the Hospital?

20

21

A. Yes, it was usually reported to  
me during the morning report.

22

23

24

25

Q. Was it a requirement that you  
be apprised of any such errors that had occurred  
during the long night shift when you weren't there?







CC.15

1

2

A. I felt it was.

3

Q. Was that something you

4

communicated to your nurses on Ward 4A?

5

A. Yes.

6

Q. I take it then, Ms. Radojewski,

7

and please correct me if I am wrong, that if there

8

was an increase in the number of detected or known

9

medication errors on those two wards during that

10

nine-month period, that is something about which you

11

would have been made aware or personally observed?

A. Yes.

12

Q. To the best of your knowledge

13

during that nine-month period was there an increase

14

in detected or known medication errors occurring on

Wards 4A or 4B?

15

A. I believe there is a note to

16

some effect in either the communication book or the

17

ward meeting book, there is some concern.

18

Q. All right. Perhaps we can

19

deal with those.

20

The Commissioner has heard evidence

21

from other witnesses, Mrs. Radojewski, that in the

22

months of October and November, 1980, there were

23

four errors involving digoxin made: three in the

24

month of October and one in the month of November.

25





CC.16

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That was a situation where we have heard the correct dose of digoxin was given at 5:30 in the morning, but in error a second dose or at least the dose was repeated at 9:30 in the morning. Are those the errors that you are referring to?

A. Yes, they are.

Q. It is our understanding that none of those errors applied to the 36 children whose deaths are of concern to this Commission.

Are you as well aware of a medication error involving Brian Gage a patient on Ward 4A?

A. Not that I recall.

Q. Are you as well aware of a medication error involving a patient by the name of Paul Murphy who was a patient on Ward 4A?

A. I don't recall.

Q. To assist you with that, Ms. Radojewski, I am showing you an incident report with respect to Paul Murphy. I would ask you to confirm whether or not that is your signature on the bottom of the incident report?

A. Yes, it is.

Q. What was the date of the filing of that incident report?





DD  
DM/PS

1

2

A. The extended date is August

3

19th.

4

Q. 1980?

5

A. 1980.

6

Q. And am I correct that Paul

7

Murphy appears to have received the wrong amount of  
digoxin at 2100 hours on August 19th, 1980?

8

A. Yes.

9

Q. He in fact received too much,

10

there was an error in the calculation of the appropriate  
dosage?

11

12

A. Yes.

13

Q. Mr. Registrar, could you show

14

the witness if you would, please, Exhibit 80C, which  
is Volume 3 of the medical record of Paul Murphy.

15

THE COMMISSIONER: Is this to be an

16

exhibit?

17

MS. CRONK: Yes, please, sir, if you

18

would make that an exhibit.

19

THE COMMISSIONER: Yes, all right,

20

364.

21

---EXHIBIT NO. 364: Patient Incident Report re.

22

Paul Murphy, 19.08.80.

23

Q. I would ask you to turn first

24

if you would please, Ms. Radojewski, to page 15, and

25







1

2

2

3

4

5

I am going to suggest to you that according to page 15 of the medical chart of the child he appears to have been admitted to the hospital from the cardiology clinic on August 19th, is that correct?

6

A. Yes.

7

8

Q. And he had been in and out of hospital as I understand it for a number of years.

9

A. Yes.

10

11

12

Q. Can I ask you now if you would to turn to page 124 of the chart, which is a portion of the progress notes that were completed on the child.

13

14

A. I am not sure if I have the correct number. I can't read it.

15

16

17

18

19

20

Q. They are difficult to read, but it is the top right hand corner and I direct your attention to the nursing note which appears at the top of that page, Ms. Radojewski. It would seem on the basis of this note that the child was admitted to Ward 4A before 5:00 in the morning again on August 19th, would you agree with that?

21

A. Yes.

22

23

24

25

Q. If the digoxin error that appears to have occurred with respect to the child at the time on the incident report is correct, appears to have





1  
2 occurred at 9 p.m. on the evening, that is, at 2100  
3 hours.

4 A. Yes.

5 Q. And I ask you to turn now if  
6 you would please to page 142 of the chart, this  
7 is a clinical chemistry computer printout, do you have  
8 that?

9 A. Yes.

10 Q. There is a reading or a digoxin  
11 level there of 1.8 nanograms, do you see that?

12 A. Yes.

13 Q. That appears to have been  
14 recorded on August 19th, 1980 from a sample taken at  
15 10:45 in the morning.

16 A. Yes.

17 Q. To the best of my knowledge, Ms.  
18 Radojewski, this is the only digoxin level recorded  
19 on this child during his last admission at the Hospital  
20 for Sick Children. Are you aware of any other?

21 A. I don't recall.

22 Q. It appears that this particular  
23 level, or at least the sample on which the level was  
24 ultimately obtained, was drawn at 10:45 in the  
25 morning on August 19th, and later that evening at  
approximately 9:00 there was a medication error





1  
2 involving digoxin, the child seems to have received  
3 too much, according to the calculations.

4 A. Yes.

5 Q. It would appear then that there  
6 was no digoxin level taken after the happening of  
7 that error, at least insofar as you are aware, is  
8 that fair?

9 A. That's right.

10 Q. We know, however, that Paul  
11 Murphy did not die Ms. Radojewski, until four days  
12 later, that is August 23rd at approximately 10:30 in  
13 the evening. Does that accord with your recollection  
14 of the date and timing of that child's death?

15 A. Yes.

16 Q. And I would ask you to turn to page  
17 140 of the chart if you have it still in front of  
18 you, to the medication and treatment record of this  
19 child. It appears that the child continued on  
20 digoxin, a regime of digoxin therapy after the 19th  
21 of August through until the morning of the 23rd of  
22 August, am I reading those entries correctly?

23 A. Yes.

24 Q. It is also my understanding that  
25 there was a "do not resuscitate" order in place with  
respect to this child, does that accord with your







1

2

recollection?

3

A. Yes.

4

Q. Apart from the error involving

5

Paul Murphy and the one that I have suggested occurred

6

with respect to Brian Gage, of which you have no

7

recollection, are you aware of a medication error

8

having occurred involving Kristin Inwood, a patient

9

on Ward 4B?

10

A. I remember hearing the name on

4B, but I don't remember much other.

11

Q. Apart from those errors, that is,

12

the three that occurred in October, the one in

13

November involving the giving by error of a repeat

14

dose of digoxin, and the one involving Paul Murphy

15

that we have just looked at and the two I have sug-

16

gested to you, Brian Gage and Kristin Inwood, are you

17

aware of any other digoxin medication errors which

18

occurred during this nine month period on either

19

Wards 4A or 4B involving any of the 36 children

who are of concern to this commission?

20

A. I don't recall.

21

Q. One way or the other?

22

A. No.

23

Q. Do you have any recollection

24

today at all of any other medication error involving

25







dr. ex. (Cronk)

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6

2

digoxin having occurred with respect to any specific  
child on those wards?

3

4

A. No, I don't recall them.

5

6

7

8

9

10

11

Q. Dealing with medication errors  
generally on these 36 children, Ms. Radojewski, that  
we are concerned with, it is my understanding that  
apart from an error involving digoxin there was a  
further medication error involving one of these 36,  
that is an error involving Laurette Heyworth, do  
you have a recollection with respect to that  
error?

12

A. No, I don't.

13

14

15

16

Q. I am showing you another patient-  
infant report with respect to Laurette Heyworth, and  
once again it appears that the signature of the  
supervisor on that incident report is yours, is that  
correct?

17

A. Yes, it is my signature.

18

THE COMMISSIONER: 365.

19

MS. CRONK: Thank you, sir.

20

---EXHIBIT NO. 365: Patient Incident Report Re.  
Laurette Heyworth, 20.08.80.

21

22

Q. It appears, Ms. Radojewski, that  
this error took place on August 20th, 1980?

23

A. Yes.

24

25





1

2

Q. In this case the error involved  
not the drug digoxin, but rather the drug lasix?

4

A. Yes.

5

6

7

8

Q. And am I reading the incident  
report correctly if I suggest that in this case the  
error was caught in time, it was detected before  
the error had in fact been made and the situation was  
corrected?

9

A. Yes.

10

11

12

Q. So that the child in fact re-  
ceived the appropriate amount of lasix as had been  
ordered by the attending physician?

13

A. Yes.

14

15

16

17

18

19

Q. That appears to have been an  
error, as I have suggested, with respect to one of  
those 36 children involving medication error but  
not digoxin. Does this incident report help you  
in any way to recall any other medication errors  
involving either digoxin or any other drug with  
respect to any of these 36 children on the ward?

20

A. I am sorry, I just can't remember.

21

22

23

24

25

Q. That is helpful. Thank you.  
Apart from the errors that we have looked at, and those  
that I have drawn to your attention, Ms. Radojewski,  
were you at any time during this nine month period under





1  
2 the impression, or did you have the impression that  
3 there had been an increase in medication errors on  
4 either Wards 4A or 4B, apart from the ones that we  
5 have spoken about?

6 A. No, I don't recall that there  
7 was.

8 Q. For your benefit, sir, and to  
9 assist the witness, I have asked counsel for the  
10 hospital to produce to us the records of the medica-  
11 tion errors known to have occurred on Wards 4A/4B  
12 during this nine month period. I am producing a letter  
13 addressed to the Commission from Mary Thomson of  
14 Messrs. Dowling and Henderson to which is attached  
15 a schedule -- I'm sorry, sir, that is dated January  
16 11th, 1984, to which is attached a schedule or list of  
17 the known medication errors which occurred on these  
18 two wards during this nine month period of time. It  
19 includes, for example, the medication error involving  
20 Paul Murphy, as reflected by the incident report that  
21 Ms. Radojewski has identified; and the error involving  
22 Laurette Heyworth on August 28th and the incident  
23 report that has just been filed.

24 I draw your attention, sir, to the  
25 last paragraph on the first page of the letter in  
which Ms. Thomson confirms that on the basis of the







DM

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information available to counsel for the hospital with the exception of the error involving Paul Murphy, the error involving Laurette Heyworth and those about which the Commission had already heard, that is, Kristin Inwood and Brian Gage, none of the medication errors which occurred on Wards 4A/4B as listed in the schedule involved the 36 children about which this commission is concerned, sir.

MS. CRONK: That is really for your edification and assistance, I know you can't help me with the contents of that letter. I would ask, sir, that under those conditions the letter be marked as the next exhibit.

THE COMMISSIONER: Yes, all right.  
Exhibit 366.

---EXHIBIT NO. 366: Letter to the Commission from Dowling and Henderson, January 11th, 1984 with attachment.

Q. Ms. Radojewski, during that nine month period of time, again that is July, 1980 through to the end of March, 1981, was there ever an occasion which you can now recall when a member of the nursing or the medical staff on either ward suggested to you that a medication error had occurred involving a patient on Ward 4A/4B in circumstances





1

10

2

where an incident report had not been filed, was that  
ever suggested?

3

4

A. Not that I can remember.

5

6

7

Q. Would it be fair of me to suggest  
if that kind of a situation had been drawn to your  
attention, Ms. Radojewski, steps would have been taken  
to report the matter and to investigate it further?

8

A. Yes.

9

10

Q. And I take it you have no recol-  
lection of that kind of an incident having occurred?

11

A. I don't recall.

12

13

14

15

16

17

18

19

20

Q. And similarly, looking back now  
as you sit here today, over that nine month period,  
do you have the impression that there was during that  
nine month period an unusually high number, or a  
higher number than normal of medication errors on  
those wards? I am just asking for your own recollec-  
tion, Ms. Radojewski, in looking back on those nine  
months when you were head nurse on Ward 4A, do you  
have the impression that there was an incidence  
of medication errors higher than normal on those  
wards?

21

22

A. No, I am not left with the  
impression that there was one higher than normal.

23

24

25

Q. In the normal course of events





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if those kinds of errors were occurring with any degree of frequency, I think you have told us that you would have expected they would have been brought to your attention whether they occurred during the day, or during the night when you were not there.

A. Yes.

Q. Thank you. You have told us that you worked normally the eight hour day shift on Ward 4A except for those weekends when once every two months you came in to work as nursing supervisor. If an arrest and a death occurred on either 4A or 4B during the day, is that something that of necessity you would be aware of?

A. Yes, I believe I would be aware of it.

Q. That would be true even if the arrest and the death, if it had resulted in death, had occurred on 4B?

A. If it was during the day?

Q. Yes.

A. Yes.

Q. And similarly if an arrest and a death occurred at night on Ward 4A or 4B, is that something that necessarily would be brought to your attention when you were next on duty in the ward?







12

1

2

A. Not necessarily 4B.

3

Q. Let's deal then simply with 4A.

4

Would you necessarily expect that an arrest and

5

death that had occurred during the night would be

6

brought to your attention?

7

A. Yes, certainly.

8

Q. In the normal course of events

9

would it be your expectation that the members of the

10

nursing staff on 4B, or alternatively your colleague

11

Mrs. Costello, would alert you to the fact that there

12

had been a death on 4B?

A. Yes.

13

Q. We have heard in evidence from

14

a great many witnesses, Ms. Radojewski, that in this

15

nine month period with which we are concerned, and

16

commencing specifically on June 30th, 1980, there

17

was an increase in the number of arrests and deaths

18

which did occur on Wards 4A/4B. As I understand it

19

you are aware of the identify of those 36 children

who died on those wards, do I have that correctly?

20

A. Yes.

21

Q. And in some instances, as I

22

understand it, you were personally familiar with the

23

condition of the patient and the course of their

24

medical care?

25







1

2

A. Yes.

3

Q. In other instances as I understand  
it you do not have any recollection either of the child  
or of the circumstances of their death, am I summarizing  
it correctly?

6

A. Yes.

7

Q. I am showing to you now, Ms.

8

Radojewski, a list that has been prepared by Commission  
staff, a copy of which I provided to you through your  
counsel at an earlier date, of selected children about  
whom as I understand it you do have some recollection,  
either as a patient or the circumstances surrounding  
their death, is that correct?

13

A. Yes.

14

Q. And as well, the date of the  
particular child's death is listed; and the time of  
their death; the ward upon which they died; and  
on the right hand side of the page the day and  
hours that you worked at the hospital in association  
with the day of death. Do the entries in the day and  
hour of duty column accurately set out the days when  
you worked in association with the date of death of  
these children?

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A. Yes.

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Q. I draw your attention particularly to Item No. 6 - excuse me, and I will return to this, but that is Kelly Monteith. You are listed as having worked on August 18th for an 8-hour day and on August 19th for an 8-hour day.

Mr. Registrar, could you show the witness if you would please Exhibit 335 which are the WIN sheets for Ward 4A.

Could I ask you, Mrs. Radojewski, if you would please to take a look at the hours of duty for August 18th.

THE COMMISSIONER: Should we make this an exhibit?

MS. CRONK: I'm sorry, sir, yes.

THE COMMISSIONER: 367.

--- EXHIBIT NO. 367: Document entitled "Elizabeth Radojewski - (List of Relevant Children)"

MS. CRONK: Q. Do you have the entries for August 18th?

A. Yes, I do.

Q. And it is my understanding that you worked an 8-hour day shift on that day and that appears to be reflected by the WIN sheet, is that correct?

A. I actually worked a long day





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on Monday, August 18th.

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Q. That's a 12-hour day?

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A. Yes.

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Q. Is that reflected anywhere on  
the WIN sheet for August 18th?

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A. I believe this copy is difficult to see, but the notation, the copy in reviewing  
the WIN sheets that I saw, it was much clearer that  
there was "long day" written in the adjustment  
column.

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Q. So, you are interpreting the  
entry in the adjustment column as being the "LD",  
long day?

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A. Yes.

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Q. Quite apart from what --

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THE COMMISSIONER: I'm sorry, where  
will I find that?

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MS. CRONK: I'm sorry, sir, under  
August 18th.

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THE COMMISSIONER: Yes.

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MS. CRONK: Beside the name of Mrs.  
Radojewski, which is the first that appears at the  
top of the page.

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THE COMMISSIONER: Oh, yes, yes, I  
see, all right.

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MS. CRONK: Q. Apart, Mrs. Radojewski, from what is listed on the WIN sheets do you have a personal recollection of having worked a 12-hour day shift on August 18th?

A. I remember that occasionally I would work a 12-hour day if our team leader was ill and there was no replacement for her.

Q. Do you have any reason other than what appears in the WIN sheets to think that you did so on that day, August 18th?

A. I remember that I did one in the summer because that entitles me to some time off during the week, which is unusual.

Q. It could have been that day?

A. Yes.

Q. Mrs. Radojewski, apart from that mystery, if you will, could we turn please to the first child who is listed on Exhibit 367. That child is Alan Perreault. You were on duty on July 8th, the day of his death, as I understand it.

A. Yes.

Q. He died, according to the information in evidence before the Commission, at 1:45 p.m. in the afternoon on July 8th when you were working an 8-hour day shift.





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Mr. Registrar, could I ask you to provide to the witness please Exhibit 360, it is the Tour End Reports.

It is my understanding that copies of the Tour End Reports have now been made available to all other counsel.

Mrs. Radojewski, I'm sorry, could I ask you to turn please to page 6. As I understand it, at page 6 we see the Tour End Report for Alan Perreault on July 7th, that is the day before he died. I would ask you to look to the entry for the 8-hour day shift which appears on the left-hand side of the page. Can you identify the handwriting for me?

A. The entry concerning Alan Perreault?

Q. Yes.

A. It looks like Mrs. Croswell's writing.

Q. You don't recall having made that entry yourself?

A. No, that's not my writing.

Q. Am I correct in summarizing the entry on July 7th, the day before his death, as indicating that the child's condition was deteriorating, he was in fact in a poor condition?





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A. Yes.

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Q. All right. And the Tour

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End Report as well -- well, I'm sorry, as I under-

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stand it, perhaps you can simply confirm this for me,

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there was a "do not resuscitate" order in place with  
this child.

7

A. That was my understanding.

8

Q. Could I ask you to turn now

9

if you would please to the next page, page 7 of the

10

Tour End Report and again look at the entries for the

11

8-hour day shift on July 8th. This is the day of

12

his death. Is that your handwriting?

13

A. Yes.

14

Q. And that records the fact

15

of his death and the fact further that no resuscita-  
tion was undertaken?

16

A. Yes.

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Q. Were you physically present

18

for his death at the time of his arrest, to the best

19

of your recollection?

20

A. I remember seeing his mother

21

holding Alan beside his Isolette.

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Q. Do you recall, Mrs. Radojewski,

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when you reported for work on the day he died what the

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nature of his condition was, according both to the

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report that you received that morning and according to the Tour End Report that you have just looked at?

A. I don't recall the report I got that morning.

Q. Do you recall whether or not he was expected to die that day? Was he in the process of dying when you attended for work on July 8th?

A. I don't recall.

Q. Did you have any discussion concerning his death with any of the nursing staff on either Ward 4A or 4B during which it was suggested that the cause of his death was uncertain or a matter of puzzlement to the nurses who had been present?

A. I don't remember any discussion about Alan Perreault.

Q. Do you recall any discussion, and by that I take it you mean that you do not recall any discussion concerning the cause of his death or any certainty or uncertainty that may have attached to it?

A. Yes, that's right.

Q. Do you recall any discussion with anyone, be it a representative of the medical staff or the nursing staff on those wards, as to the







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timing of his death?

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A. No, I don't recall any dis-

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cussion.

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Q. Was it ever suggested to you

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at any time by any one, again be it a person from the

7

medical or nursing sides of the staff in the Hospital,

8

that there may have been some involvement of digoxin

9

in his death?

A. No, I don't recall that.

10

Q. With respect to the entries

11

which appear in the Tour End Reports, and we have

12

had this in part from other witnesses, Mrs. Radojewski,

13

and I would simply like to obtain your understanding

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of it, it is my information that a particular child

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might be listed on the Tour End Report in the first

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instance if the child's condition was considered very

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serious or if he or she were gravely ill; is that

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A. Yes.

19

Q. And in addition to that, if

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a patient was a new admission or a new transfer on to

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Wards 4A/4B, in those circumstances would you expect

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to see the patient's name and a description of his

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A. Yes, I would.

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Q. And if surgery was scheduled or some operative procedure for the patient, would you expect to see once again the name of the patient on the Tour End Report?

A. Yes, usually it was.

Q. Are there any other situations which you can now recall in which there would be an inclusion on the Tour End Report for a particular patient other than those three kinds of situations that I have just described?

A. If there was constant nursing care or shared nursing care, usually those children were listed on the Tour End Report.

Q. Was there any other situation which would normally require the entry of some kind of a remark about the child on the Tour End Report?

A. Did you say when the child had expired?

Q. No. If the child died, there would be an entry in the Tour End Report?

A. Usually there would, yes.

Q. Any other situation that you can now think of?

A. I can't recall any others at this moment.





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Q. All right. When you came on during the normal course of your hours of duty for an 8-hour day shift, would you have available to you the Tour End Report from the previous shift?

A. No.

Q. All right. When would you, during the course of an average day, see the Tour End Report for the previous shift?

A. I didn't see them.

Q. All right. Did you have any involvement in the completion of the Tour End Reports for the days when you were on duty?

A. Yes, I did. The initial part of it was started by the night nurse, meaning that she did the parts where it says the nurse in charge and I filled it in, what I could, for my day shift and sent it to the nursing office by, usually three o'clock.

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Q. All right. I take it then that on every day when you were in the Hospital you would have some involvement in the completion of the tour end report for your eight-hour day shift?

A. Yes, except when I was Nursing Supervisor.

Q. On the weekends?

A. Yes.

Q. Could we turn then please to the next child, that is, Andrew Bilodeau. He died on July 22nd, 1980, according to our information at approximately 2 o'clock in the morning on Ward 4A. He had been admitted on July 19th, 1980, which was a Saturday, Mrs. Radojewski, to assist you. It is my understanding that that was not one of the weekends when you were working as a nursing supervisor on Ward 4A/4B, is that correct?

A. Yes, that's correct.

Q. Did you in fact see this child on the day of his last admission to the Hospital?

A. Can you repeat that for me?

Q. Did you in fact see this child on the day of his last admission to the Hospital, that is, July 19th, which was a Saturday?

A. No, I didn't see him on that day.





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Q. As I understand it however you did work on Monday, July 21st, the day before the child died. Do you recall seeing him on that Monday?

A. Yes.

Q. All right. What was the nature of the condition when you saw him that morning?

A. I recall him as looking fairly ill to me. He was in a small, what we call a stork bed in a corner in Room 418. I'm a little bit confused if that's how he was early in the morning but that's how I remember him when I left that day. As I recall, they had him at the head of a bed elevated in a sling, what we call a cardiac sling. I'm quite sure I remember oxygen.

Q. Do you recall anything else about his condition when you left work that day?

A. He had an echocardiogram done in the afternoon which confirmed the diagnosis. I remember he looked quite ill to me as I was leaving that day.

Q. You have told me, Mrs. Radojewski, that you remember seeing the child in a cardiac sling. Can you explain for us what that is?

A. It's not really a device, we just take a piece of linen and usually with these





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very small infants, we use a very long diaper,  
attach it to the top of the bed with pins and sit  
the child on it. So, essentially the child is  
propped up in bed with the head of the bed elevated,  
otherwise, infants would slide right down to the  
bottom of the bed.

Q. All right. Is it a method then  
really of ensuring that an infant is elevated in a  
sleeping posture while they're in the bed?

A. Yes. They don't always  
sleep, but yes.

Q. You have told us I take it  
that it wouldn't be unusual to see infants on that  
ward in that position?

A. It's unusual to see them lying  
down.

Q. Was this child lying down in  
the cardiac sling?

A. No.

Q. So, this was in fact the norm,  
that they be in a cardiac sling?

A. Yes.

Q. There is nothing unusual about  
that feature?

A. No.







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Q. Right. And you have also told us that the child as best as you can recall it may have been in oxygen when you last saw him the day before he died?

A. Yes.

Q. And having regard to what we know were the difficulties that many of these children had while they were on the cardiology unit, I take it that that too would not be unusual to see a child in oxygen?

A. No, it's not unusual.

Q. Was there anything unusual in the fact that he had an echocardiogram performed that afternoon?

A. It was my feeling, I remember Andrew Bilodeau for that reason I had felt that he should have had his echocardiogram very soon after his admission and not waited over the weekend.

Q. Well, we know that he was admitted on the 19th, which was the Friday, July 19th. Are you saying then when you came into work on the Monday the echocardiogram had not been done but it was in fact carried out that day?

A. Yes.

Q. All right. When you left work







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that day as best as you can now recall it was Andrew Bilodeau considered to be at imminent risk of death?

A. Not that I recall.

Q. Was his condition critical at that time in your judgment?

A. No.

Q. Could I ask you if you still have the tour end reports there, to turn if you would please to page 8. This is the tour end report, Mrs. Radojewski, for July 19th, the day of his admission. I take it he would be automatically listed on the tour end report from what you have told us on that day simply because he was in fact a new admission to the ward on the 19th?

A. Yes, he was transferred from another hospital.

Q. And if you would take a look at page 9 then if you would, these are the entries for July 21st before he died. If we look at the face side, or the front side of that page, we know that you worked that day. I don't see any mention of Andrew Bilodeau. Do I correctly infer from that as you have suggested that when you left work at the end of your eight hours of duty you did not consider





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his condition critical and did not list him as

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seriously ill on the tour end report at that point;

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page 9, on the front.

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MR. ROLAND: I think it is on the back side. The reason it is on the back side is that you can't get all the babies on the front side so it slides over the back side.

MS. CRONK: That is helpful. I am grateful to my friend.

Q. Was the entry then on the back of page 9 made during your 8-hour day shift on the 21st of July?

A. Yes, it was.

Q. That records as well later in the day the death, the fact of his death at 1:45 in the afternoon although the time isn't mentioned?

I'm sorry, it records your assessment of his condition when you left that day. Do I have that much correctly?

A. Yes.

Q. And then later after you had left it records the fact of his death during the long night shift? On the right-hand side of the page?

A. Yes. It is difficult to read.

Q. Is there anything in the condition which is described on the back of the Tour End Report for July 21st other than the fact of his death which suggests to you that the child's condition







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FF2 2 deteriorated in a significant fashion after you  
3 left work?

4 A. The fact that he had been  
5 given his -- you mean the other night entries?

6 Q. Yes.

7 A. The complete 24 hours?

8 Q. Yes.

9 A. The fact that he was given  
10 his digoxin intravenously and another dose of Lasix  
indicates that he may have deteriorated somewhat, yes.

11 Q. When you learned of his  
12 death, Mrs. Radojewski, having regard to the fact when  
13 you had left the day prior you did not regard his  
14 condition as being critical, you did not regard him  
15 as being at imminent risk of death, were you sur-  
prised by his death and did you regard it as unexpected?

16 A. I remember being somewhat  
17 surprised, yes.

18 Q. Were you concerned as to what  
19 had caused his death?

20 A. I was informed of his  
21 diagnosis and I know that from the experience I had  
22 children with that diagnosis are at risk.

23 Q. Are you referring now to the  
24 results of the Echo cardiogram?  
25





Radiojweski  
dr.ex. (Cronk)

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A. Yes.

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Q. Were they known to you when  
you left the day prior at the end of your shift?

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A. I don't recall. I know that  
he had it done late in the afternoon, but I can recall  
that I remember his diagnosis but I am not sure when  
I learned of it.

8

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Q. All right. What feature of  
his diagnosis are you referring to?

10

A. The truncus arteriosis.

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Q. When you learned what the  
results of the Echo cardiogram had been and that was  
his diagnosis, did that serve to reassure you in any  
way as to why the child had died?

15

A. It was explainable to me, yes,  
by his diagnosis.

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Q. During the course of the day  
when you were at work having learned of his death,  
did you have any discussion with any members of the  
nursing staff, be they from 4A or 4B, during which  
it was suggested that there was some degree of un-  
certainty in their minds as to why the child had died?

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A. Not that I recall.

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Q. Do you recall having any  
discussion with any of the physicians associated with





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dr.ex. (#Cronk)

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the Cardiology Unit in which doubt of any kind was expressed as to why the child had died?

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A. In the communications book or the ward meeting book, I am not sure which one, I had made a note that I had talked to Dr. Contreras, and Andrew Bilodeau I believe was one of the ones I had talked about.

8

9

MS. CRONK: Mr. Registrar, could you show the witness, if you would please, Exhibit 300.

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Q. If I could refer you to the first tab, Mrs. Radojewski --

12

A. Yes.

13

14

Q. -- the entry at page 5 for July 31, 1980, do you have that?

15

A. Yes.

16

17

Q. Is that the note to which you are referring?

18

A. Yes.

19

Q. And is that your note for July 31st?

20

A. Yes, it is.

21

22

Q. Can you help me, please, as to how you now recall you spoke with Dr. Contreras about this child?

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A. In reviewing the communications







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book I made a note in the column that I had talked with Carlos, and that is Dr. Carlos Contreras.

Q. You are referring to the handwritten notation on the left-hand side of the page?

A. Yes.

Q. We will come to the matter of Amber Dawson and Lillian Hoos in due course, but do you recall now, Mrs. Radojewski, having a specific discussion with Dr. Contreras concerning the deaths of those three children?

A. I don't recall it other than it being written in this book.

Q. Do you recall what Dr. Contreras said during that discussion with respect to the cause of death of Andrew Bilodeau, if anything?

A. Other than what is written in this book I don't recall.

Q. Do you know when --

THE COMMISSIONER: Where is the reference to Dr. Contreras? Where do you find that? Or is there --

MS. CRONK: Yes, sir. On the left-hand side of the page in handwriting it says "Talked to Carlos", on the left-hand side of the page.







Radojewski  
dr.ex. (Cronk)

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THE COMMISSIONER: Oh, yes, I see.

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MS. CRONK: Q. And I take it that

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is Dr. Contreras' first name?

5

A. Yes.

6

Q. Do you recall speaking to

7

Dr. Contreras on July 31st or were you recording a  
conversation that had occurred earlier?

8

A. I usually record the conversa-

9

tions as I had them, so I am sure I recorded the

10

conversation I had on July 31st on the 31st.

11

Q. Did you have any particular

12

reason for raising with Dr. Contreras the death of

13

Andrew Bilodeau?

14

A. It may have been a concern

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that I had or, in looking back, it may have been a  
concern that was raised.

16

Q. Do you recall what your con-

17

cern was?

18

A. No, I don't.

19

Q. During the course of that

20

discussion with Dr. Contreras was it suggested by --

21

I'm sorry, who was there other than yourself and

22

Dr. Contreras?

23

A. I don't recall. I believe

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it was just the two of us.

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Q. Was it suggested to you at any time, be it by Dr. Contreras, any other physician or any member of the nursing staff, that there might have been some involvement of a drug in contributing to or causing this child's death?

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A. There was no discussion.

7

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Q. Was it ever suggested to you by anyone that there might have been a drug that either contributed to or caused this child's death as best as you can now recall?

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10

11

A. No.

12

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Q. As best as you can recall was that matter raised at all during your discussion with Dr. Contreras?

14

15

A. No.

16

17

Q. Did you discuss this child's death with any other physician associated with the Cardiology Unit other than Dr. Contreras?

18

19

A. No, I didn't.

20

MS. CRONK: All right.

21

Sir, I am about to move to another topic.

22

THE COMMISSIONER: All right. Until ten o'clock tomorrow morning then.

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--- whereupon the hearing was adjourned at 4:30 p.m. until Tuesday, the 28th day of February 1984, at 10:00 a.m.

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